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PHYSICAL FITNESS IN TERMS OF PHYSIQUE, DEVELOPMENT AND BASAL METABOLISM

WITH A GUIDE TO INDIVIDUAL PROGRESS FROM INFANCY TO MATURITY: A NEW METHOD FOR EVALUATION

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A new method for evaluating physical fitness, based on the use of a grid to aid in this purpose, is described in the present paper. The method is particularly adapted to clinical work, since it requires as initial measurements merely routine data on weight, height and age. In return for these data, and these alone, it supplies objective ratings on physique (body build), development, nutritional grade, physical status and age advancement and, in addition, information on certain other items of importance. A concrete record is thus constructed which complements the subjective result gained by clinical examination. It is, therefore, a special purpose of this paper to show how the grid may aid medical examiners in judging the individual physical state and progress during the long period extending from the close of infancy to fully established maturity.

THE NEED FOR A NEW METHOD

The need for an instrument of this kind is widely felt. Souther, Eliot and Jenss [1] have remarked:

"With the public conscience demanding protection of the health of the child and the school medical services expanding to meet this need, the development of a simple economical but accurate means of assessing the child's state of well being or physical fitness is in order."

Today much of the information in medical records which refers to physical fitness is summed up in very general phrases such as "well developed and well nourished." In spite of countless attempts to standardize various physical dimensions and repeated exhortations to use them with understanding, physicians, school and public health officials and even laymen have come more and more to treat simple physical measurements, such as weights and heights, as all but worthless. The situation has not been remedied by the introduction of more extensive measurements comprising so-called batteries of tests.[2] Not only have recommendations been made to measure many different diameters, lengths and circumferences of the body and even thicknesses of the skin and subcutaneous tissues in the trunks and limbs, but also rather ambitious plans have been proposed to estimate the content of vitamins, hormones, minerals and other substances in blood and urine, as well as to undertake roentgen studies of bones and performance tests on heart, lungs and muscle.[3]

This trend toward making the routine of examination and the methods of dealing with the troublesome question of physical state continually more complicated has been encouraged by repeated failure to establish consistent and reliable standards of comparison for simple physical measurements.

The difficulties in the problem are important and should be touched on briefly. The success of estimating physical fitness by clinical examination has found scarcely more than 50 to 70 per cent agreement between experienced physicians.[3] Tables of height and weight, even when they are used in conjunction with medical estimates of physicians, have repeatedly been shown to possess no more than 60 per cent overall reliability in differentiating between persons of satisfactory and of unsatisfactory physical grade.[4] Finally, indexes of nutrition, or of "body build" as they have been variously called,[5] have failed notably to select subjects in under par classes.[5a]

From the standpoint of national health the situation has been frankly discouraging, in spite of ever increasing funds and efforts devoted to the study of child development. Two facts are striking:

In the first place, no one denies that the tests mentioned, as well as others that could be enumerated, have their own proper place, namely in private practice or in research, and yet even then chiefly under conditions of hospitalization. But no matter how worthy or how well deserved the application of these intricate technics may be in selected cases in which time, expense and other items are of no great consequence, they remain, without question, thoroughly unpractical for large groups and hence precisely where the need for a screen is usually greatest.

Meanwhile, measurements of height and weight are being taken with routine care and also with about the same attention paid to them as to a morning bath, namely as part of a "well organized health program." Under the circumstances, those concerned with child welfare, including (in certain communities) nurses and teachers in addition to medical officers and private physicians, have continued to assess a child's physical makeup by methods long recognized as crude and not trustworthy but nevertheless still in use because of the want of anything better for the purpose. The present scheme, as embodied in the grid, is offered to fill this urgent need.

While the demand for a reliable aid to medical examiners in evaluating physical fitness is, as just outlined, an important stimulus for submitting a solution to the problem, no new method, however accurate or reliable,

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1. Souther, Susan P.; Eliot, Martha M., and Jenss, Rachel M.: A Comparison of Indices Used in Judging the Physical Fitness of School Children, Am. J. Pub. Health **29**: 434 (May) 1939.

2. Report on the Work of the Group of Experts Appointed to Study Methods of Assessing the State of Nutrition in Infants and Adolescents, Bull. of Health Organ., League of Nations **6**: 129 (April) 1937.

3. Franzen, R.: Physical Measures of Growth and Nutrition, New York, American Child Health Association, 1929. Report.[2] Jones.[3]

4. Manny, F. A.: A Comparison of Three Methods of Determining Defective Nutrition, Arch. Pediat. **35**: 88 (Feb.) 1918. Dublin, L. I., and Gebhart, J. C.: Do Height and Weight Tables Identify Undernourished Children? New York, New York Association for Improving the Condition of the Poor, 1924.

5. Clark T.; Sydenstricker, E., and Collins, S. D.: Weight and Height as an Index of Nutrition, Pub. Health Rep. **38**: 39 (Jan. 12) 1923. Jones.[3]

5a. The failure of various methods of assessing physical fitness mentioned in the text has just recently been restated in a comprehensive review by Jenss, Rachel M., and Souther, Susan P.: Methods of Assessing the Physical Fitness of Children, Children's Bureau Pub. 263, Washington, D. C., Govt. Printing Office, 1940.

should be proposed unless it meets, in addition, the three conditions stipulated by Jones.[6] These, in brief, are:

1. Measurements should be restricted to those which can be made in routine examinations at office or school.
2. No recalculation of basic data should be required.
3. No extra time or labor should be involved.

These are severe conditions but, as the present paper shows, they can be and have been completely met.

THE ROLE OF GROWTH AND DEVELOPMENT

From the clinical point of view, it is axiomatic that a child who fails to grow properly is not healthy and that such a child, accordingly, should become the subject of medical examination. Again, from a broader point of view, the chief burden and concern of parents is to provide the most favorable conditions for growth and development of their children. Similarly, the main object of all organized child health work is to facilitate growth and development, whether this is explicitly stated or not. There is, in each of these endeavors, an unmistakable implication that deviations in growth and development are connected with changes in health, and even that they may constitute initial signs of otherwise unsuspected disease. For all these reasons the present method of evaluating physical fitness has been specifically designed to provide tangible access to the phenomena and events of growth and development.

The chief principle underlying the grid technic is, therefore, the consideration of the individual child as a whole and especially in relation to his own past record of progress. Now, as far as young subjects aged from 2 to 20 years are concerned, nothing so completely characterizes them in these two respects as their own growth and development. But a child's proper development depends implicitly on its proper growth, and this in turn depends not only on proper food supply but on proper physiologic use of food. Satisfactory progress implies maintenance of this delicate balance between food, digestion, metabolism, nutrition, growth and, finally, development. In a complicated chain such as this some variation of response is inevitable. Differences become especially imposing if observations are extended to many children. Such variations, however, have sometimes been taken to signify that growth is too irregular to have any valuable diagnostic worth. There are, on the contrary, some very significant events of growth and development which recur with startling regularity. Fortunately, both the regular and the irregular features can be detected by the grid, and one is thus able to obtain a clearer picture than otherwise of the causes that give rise not only to variation in the individual subject from time to time but also to those physical differences that distinguish person from person.

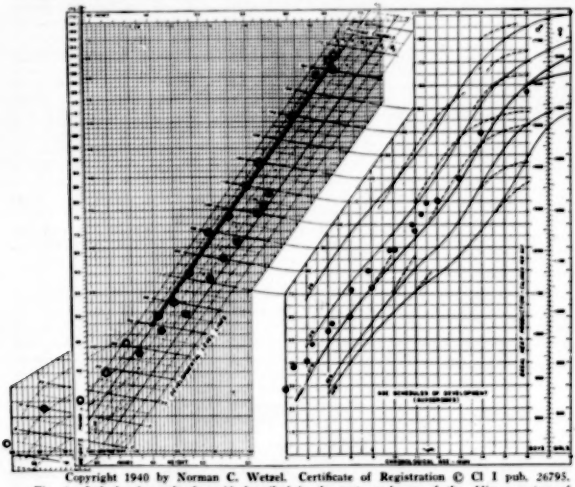

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Fig. 1.—Left hand panel: the grid described in the text, made up of the oblique system of seven principal channels of constant physique subdivided by isodevelopmental level lines. Right hand panel: representative age schedules of development (auxodromes) with percentage of children on or ahead of each schedule, showing how widely separated in time (age) children of the same developmental level may actually be; boys are represented by the solid lines, girls by the broken lines. The small dots in the *M* channel identify the successive yearly levels indicated by the 67 per cent curve, which is taken as the standard of reference; a child whose curve is ahead of this is advanced in development, one whose curve follows behind the standard is retarded in development. The open circles ○ represent the developmental progress of subject F from February 1892 to February 1908;* the solid circles ● represent subject D from September 1933 to September 1940. Estimates of basal heat production and daily caloric intake are read directly for the corresponding level and sex. (The original chart measures 9 by 11½ inches.)

GRID TECHNIC OF EVALUATING PHYSICAL FITNESS

A grid rating of physical condition is established in the following way: Measurements on weight, height and age, the traditional data collected over and over again in everyday clinical work, are entered, according to directions, on the grid illustrated in figure 1. From a point so plotted, or from the curve defined by several points representing successive observations, it becomes immediately possible to elicit quantitative information on all the items listed in table 1. The first five are necessary and also sufficient for an objective rating of physical fitness; the remaining items have only accessory though often valuable significance. If a single observation (one point only) is available, information on item 3 is presumptive and not final until it is definitely established, as explained later, by a subsequent measurement.

Under ordinary conditions the changes in item 1 through item 8 (table 1) are going on simultaneously throughout adolescence. This has always been a major obstacle to the appraisal of physical fitness by other methods. A characteristic and important property of the grid technic, however, is that it enables an examiner to measure and consider each item separately or in any combination that might be required.

Besides information on the tabulated items, one obtains, for successive annual or semiannual observations, not only a record of progress already achieved and an impression as to how satisfactory this has been but also an indication of what forthcoming progress may be expected for each particular subject in the near as well as in the more distant future.

6. Jones, R. H.: Physical Indices and Clinical Assessments of the Nutrition of Schoolchildren, J. Roy. Statist. Soc. **101**:1 (Part 1) 1938.

The Grid Itself.—This is shown in the left hand panel of figure 1.[6a] It consists of seven principal channels of physique, symmetrically disposed about the middle, or *M*, channel and diagonally traversing the field graduated in metric and customary units of weight and height. The distance along the channels is subdivided equally by parallel isodevelopmental level lines.

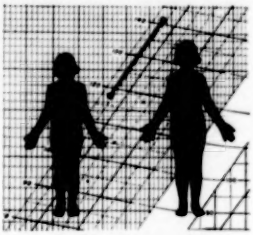

Fig. 2.—Channelwise progress of a stocky girl (L. D.) in A_3, from level 117.5 to 142. Note preservation of same physique during the period from 10.5 to 12.5 years.

The supplementary charts in the right hand panel contain (*a*) five representative curves henceforth referred to as auxodromes,[7] which show how upchannel progress for both boys (represented by solid lines) and girls (represented by broken lines) is scheduled to proceed with increasing age, and (*b*) a scale alining basal heat production to developmental levels.

The foregoing elements (grid, channels, level lines, auxodromes and basal heat production values) will now be described more thoroughly in connection with a detailed explanation of the specific meanings that pertain to the various items listed in table 1.

Channels of Constant Physique.—The seven principal channels designated A_3, A_2, A_1, M, B_1, B_2, B_3 (the A and B denoting above and below middle M, respectively) are straight line paths for the duration of school life, that is from 6 to 18 years and beyond. During the preschool period, however, the channel trend is changing continuously, as shown by the dotted curves. Final settling into a channel may be delayed a year, but only in exceptional cases will this be later than the age of 8 years. Thenceforward healthy development continues in an established channel as though this were a preferred path, notwithstanding its apparently narrow width.

The records of two boys, F from 1892 to 1908 reported by Guttmann[8] and D from 1933 to 1940,

TABLE 1.—*Items Entering into the Grid Evaluation of Physical Fitness*

1. Physique (body build)	5. Relative age advancement or retardation, as the case may be
2. Developmental level	6. Maturation
3. Nutritional grade	7. Basal heat production
4. Physical status	8. Daily caloric intake

shown respectively by the open and solid circles in figure 1, are evidence of the tendency to proceed channelwise. This fundamental property of growth and development has obviously not been altered in the last forty years. The grid thus enables each subject to become his own standard of comparison.

This singular characteristic of healthy development to proceed channelwise and, in so doing, to keep body build or physique constant, is clearly illustrated by the silhouettes shown in figure 2, which have been constructed to standard size with utmost care. From these it is plain that body shape has remained substantially the same during a period of two years in which development has advanced from the 117.5 to the 142 level. The silhouettes indicate the type of physique characteristic of subjects in channel A_3.

Accidental variations[9] such as occur in all observations are astonishingly small and always well within the width of a channel. Indeed, it may be stated as a simple and practical rule that normal variations do not exceed one-half channel per 10 units of advancement. Changes greater than this are cause for thorough physical examination and investigation. Continued cross channel advance, bearing left or right, is definite evidence of systematic deviation which, as shown in the next section, will soon lead to recognizable changes in body build and nutritional and physical states.

Paths of Changing Physique.—Two, and only two, types of changing physique occur. They are illustrated by the standard size silhouettes and their respective curves in figures 3 and 4. The curve directed upward leads toward obesity, whereas the other, directed downward, is clearly indicative of oncoming "malnutrition." In both cases a change in the channel has taken place and therefore a change in physique. In any case (fig. 4) the change in physique is measured by the projection of the curve on a developmental level line as shown by the arrow.

So long as external and internal conditions remain the same, no deviation of path is to be expected. But if deliberate therapeutic changes in diet, for example, are introduced, corresponding changes in the curves will follow.

Thus, in the severely malnourished boy in figure 5, whose original silhouette quite clearly defines the state of "nothing but skin and bones," treatment in a convalescent hospital resulted in the improvement displayed in the curve and in the second silhouette.

The opposite effect is illustrated in figure 6, which shows the results attained in an obviously obese child whose only fault was overeating and who became, under supervision, a healthier child as she entered the normal channel of medium build, A_1, for which her natural frame was suited and presumably intended.

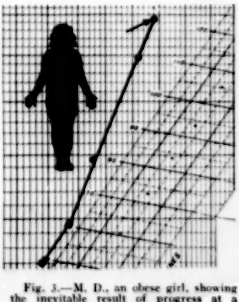

Fig. 3.—M. D., an obese girl, showing the inevitable result of progress at a slope greater than that of the channel.

A plotted point in any of the seven principal channels or in any that lie above or below them gives an immediate indication of body build or physique at that point. Study of upchannel and cross channel progress has sufficiently indicated that the obese-plump, stout, stocky types are found above and in the upper A channels; the medium types of body build are represented in the three outer channels; and, so far as build itself is concerned, the genetically slender, linear, thin

6a. See figure 7 for greater detail, especially in upper channel regions.

7. Derived from the Greek words αὐξάνω, to grow, and δρόμος, a course.

8. Guttmann, M.: Einige Beispiele individueller körperliche Entwicklung, Ztschr. f. Kinderh. **13**: 248, 1916.

9. Minor irregularities and differences due to circumstances which cannot always be completely controlled; e. g., diurnal variations traceable to meals, rest and emunctory functions, and error of personal equation.

examples are in the lower *B* channels (fig. 7). A change in physique, moreover, is measured simply by a change in the channel.

Developmental Level.—Physical development is measured on the grid by means of the isodevelopmental level lines. These subdivide the distance along the channels into equally spaced units, each 10 units being shown by solid and each 5 units by broken lines. The zero base is taken somewhat below the entrance to the linear path and corresponds to the level which marks the end of infancy and thus the beginning of adolescence.[10] All points on any level line are equally removed from the zero base line. The shortest path for development is strictly along the channel, all other paths being longer, though this fact cannot be verified in figure 1 owing to the effect of scale. Thus development may be measured independently of physique and independently of upchannel or cross channel progress, a result hitherto impossible with any of the usual "indexes of nutrition" or body build. Hence, 2 subjects both of whom have arrived at level 100, no matter how or in which channel, are specifically to be considered as being on the same developmental level. For the present, the units of development are arbitrary. In a later section their calibration in terms of power, or calories of basal heat output daily, will be explained. This is also a new result showing that physical development need not be considered a thing apart, but rather that structural change and physiologic (metabolic) change can be made co-servants in clinical appraisal.

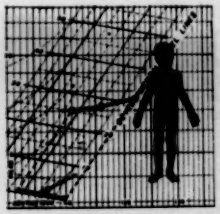

Fig. 4.—G. M., a malnourished boy aged 9 years with a telltale direction to his curve. Arrow points to graphic measure of change in physique. His developmental level of 32 at 9 years signifies that he is retarded by three years, thus giving him a developmental age of 6 years, according to the 67 per cent standard.

Nutritional Grade.[11]—As indicated before, channelwise progress is the preferential path pursued in health. It is, moreover, the only mode of developmental advance which proceeds without change in physique. Optimum nutrition, accordingly, may be defined as the sum total of those processes which together enable development to proceed along the contour lines of one's inherited physique. Thus normal or optimum nutrition in the clinical sense is indicated whenever the slope of a given child's curve is equal to that of the channel, provided progress is also on a satisfactory time schedule, as explained later.

If, however, the gradient or slope of a particular curve departs from that of the channel, one of two opposite types of nutritional state is in the making. Curves proceeding less steeply than the channel will be associated not only with change in physique toward a more slender body build but also with a state of comparative malnutrition. Causes for this kind of progress need not, of course, be traceable solely to defective diets, for all possible causes—e. g., dental caries, tonsils and adenoids, fatigue and poor hygiene—will likewise require to be looked into.

Similar considerations hold for curves proceeding more steeply than the slope of the channel system. In this event, change in physique toward ultimate obesity ensues, and the subject, meanwhile, is becoming "overnourished." Here, again, diet alone need not be at fault, for the endocrine system will also demand attention.

To put these results briefly, it may be said that a curve of development which shows significant departure from the channel slope indicates simultaneous changes in (*a*) nutritional grade and (*b*) body build; each change is separately indicated by the grid. The slope or gradient of the curve is the measure of what clinicians, in assessing physical fitness, call the state of nutrition, whereas the projection of the curve on the channel axis is, as before, the measure of coincident change in body build.

Physical Status.—This otherwise troublesome term now takes on a perfectly definite and distinct meaning of its own which may be explained as follows: It signifies precisely that resultant physical state which has been produced by the combined effects of growth, development and nutrition cumulated to the moment in question. Graphically, some particular physical state will therefore be associated with every height-weight point in the grid field. But, since the complete determination of physical status depends on knowledge of the past history, the specific state in a given subject associated with any point cannot be unconditionally defined until the mode of approach to that point (of which there are an infinite number) has been revealed. This is equivalent to saying that the graphic determination of physical status (item 4, table 1) depends on all three preceding items in the table. It also means that the combination of items 1, 2 and 3, which together give 4, can be represented graphically not by a height-weight point itself but rather by such a point as terminus of a directed line segment (vector) originating in some previous observation.

On the practical side, fortunately, the impossibility of determining the mode of approach to a given point by a single observation, and hence the limitations thus imposed on the determination of item 3, does not prevent an approximate evaluation of physical status, as the following considerations show. Every point, when plotted, may be resolved by means of the grid into two parts: (*a*) the physique component, as represented by the channel in which the point lies, and (*b*) the developmental component, as given by the respective level scale. This resolution, therefore, takes care of items 1 and 2 in table 1, with the result that, to every point, there corresponds one, and only one, combination of physique and development. Knowledge of this combination, which every point gives, constitutes the greatest share of

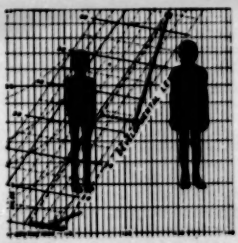

Fig. 5.—J. H., another undernourished boy, showing response to convalescent care. The change in physique is characteristic and is measured by the projection on the cross channel axis.

10. Wetzel, N. C.: On the Motion of Growth: XVI. Clinical Aspects of Human Growth and Metabolism with Special Reference to Infancy and Preschool Life, J. Pediat. 4: 465 (April) 1934.

11. With due regard for already established meanings attached to the term "nutrition" itself, and especially to the fact that it has been used on some occasions to refer simply to single elements in the diet, on others to the whole nutritional process and, finally, in clinical work to various rather well recognized states of health, there is need for a cognate term which will connect nutrition per se with the various types of developmental progress already described.

information required for a complete estimate of physical status. Hence, even if measurements are limited to a single observation, a graphic estimate of physical status can at least be partially made. It remains provisional until a second observation establishes the trend required for a determination of the nutritional gradient (item 3).

TABLE 2.—*Grid Ratings of Physical Status Corresponding to Location of Points in Various Channels*

Physical Status	Channel	Per Cent of 2,000 Cases at Developmental Level = 100 and Economic Youth = 2.4
Obese (O)	A_1, A_2	6.8
Stocky (S)	A_3, A_4	9.6
Good (G)	A_5, M, B_1	61.6
Fair (F)	B_2	13.9
Borderline (B)	B_3	5.9
Poor (P)	B_4	2.4

Pending this, however, a tentative estimate is justified on the ground that subjects of "medium build" and "good nutrition" are in and tend to progress along the center channels; the stocky types, whose nutrition is not in question, travel in the upper two channels, whereas the slender, linear types, whose nutrition is often doubtful, are found in the two lower channels and below (fig. 7). For ready reference the grid ratings of physical status as determined by the location of individual plotted points are given in table 2.

Thus, according to table 2, any point lying in channel A_3 represents a subject of the stocky and well nourished type. A point in B_2 represents a child whose physical status can be considered only "fair," that is, in doubt, but not yet so greatly in doubt as a point in B_3, which is "borderline." In A_4 and above are those of increasing grades of obesity beginning, perhaps, with the dignified "stout" or "overly plump." In B_4 and below are those whose physical status is frankly "poor."

No difficulty will arise in distinguishing between the meanings here placed on "physical status" and "physique" if it is remembered that the latter refers only to body build and is therefore but one of the items required to define physical status, the others being items 2 and 3 of table 1.

As the final column of table 2 shows, one may expect roughly 30 per cent of children to be in a physical state requiring medical investigation and supervision. This estimate agrees with earlier observations [12] and serves to show that the grid technic is capable of expressing independent ratings which may be used by medical examiners as a guide in screening the under par child.

The subjects in channel B_2 (fair) are of special interest. It has been found [13] that physicians cannot agree by more than 50 per cent on medical ratings of children in this channel, although they agree among themselves on 94 per cent of subjects in all other channels, a figure which greatly exceeds previous trials at correlating medical opinion with some objective measure of physical state and nutrition. For this reason a child in the fair or B_2 channel should routinely become the subject of examination in order to determine whether heredity and background account for its being there or whether disease is at work. Similar warnings hold true for the borderline B_3's. It may be taken for granted that the children of the B_4 group are "poor" and require not merely examination but treatment as well. Those above A_3 likewise need careful watching, first to prevent their going still farther beyond the outer channel and second to remedy their obesity. A course of development directed upward and out of bounds, when once initiated, tends to proceed with all but unbelievable momentum (fig. 3).

Relative Age Advancement or Retardation.—Until now, no mention of the time element in developmental progress has been made or required. Attention has been directed solely to matters of body build, developmental level, nutritional grade and, lastly, physical status in which all other elements are embodied. This order of procedure does not signify that time or speed of progress is not essential to a final rating; on the contrary, it helps to emphasize the important role of age, which may next be dealt with from a more appropriate point of view.

The Auxodromes.[1]—These curves, which are shown in the right hand panel of figure 1, measure relative age advancement or retardation as the case may be. To put the matter somewhat differently, it may be said that the curves display advanced, normal and retarded patterns of developmental progress and may, accordingly, be taken to show how physical development proceeds with respect to age during its channel course on the grid. These curves are, in a very real sense, schedules of progress which indicate how far the advanced, regular and retarded child may be expected to have developed at a given age.

The percentage figure at the lower end of each curve indicates the relative number of children who are on or ahead of the respective schedule. Thus, only 2 per cent will have advanced in their development at successive ages as far as or farther than the uppermost curve calls for; 67 per cent will have reached the levels given by the center auxodrome on or before the corresponding ages to which it refers; finally, 98 per cent of children will therefore certainly have advanced as rapidly as the lowest curve, so that only 2 per cent remain behind this in their development. The 67 per cent curve is taken as the standard of reference by which advancement or retardation in a given child may be measured.

Distinction is made between boys and girls. During the earlier stages from 5 to 9 years, to which Stratz [14] referred as "neutral childhood," boys and girls follow a common course to the lower point of bifurcation. Thenceforward girls (broken curves in figure 1) tend quite characteristically to proceed ahead of boys (solid

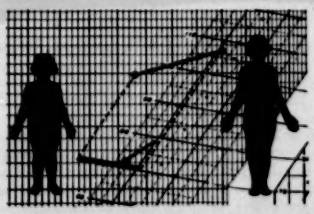

Fig. 6.—J. D., an obese girl showing a conspicuous change in physique as a result of dietetic therapy.

curves in figure 1) toward their own upper boundaries and with earlier cessation of development.

The average rate of progress by these schedules is approximately one level line a month. This figure may

12. Chenoweth, L. B., and Selkirk, T. E.: School Health Problems, New York, F. S. Crofts & Co., 1937, chap. 6. The White House Conference on Child Health and Protection, J. A. M. A. 95:1765 (Dec. 6) 1930. Manny, F. A.: Defective Nutrition and the Standard of Living, Survey 59:698, 1918.

13. Discussed in a later section dealing with statistical background.

14. Stratz, C. H.: Der Körper des Kindes und seine Pflege, ed. 11, Stuttgart, F. Enke, 1920.

conveniently be referred to as "a point a month" for developmental advancement during all adolescence irrespective of seasonal effects. However, as the slight but definite change in the slope of the curves clearly shows, development does not take place at constant time rates. Following the steep rise at 6 and 7 years there is a clear-cut tendency to proceed more slowly, the lag effect being most conspicuous in the lowermost curve. The lag, in turn, is followed by the final episode of acceleration associated with puberty.

The set of five auxodromes thus represents a family of curves that may be used as a direct guide with which to compare the personal curve of the subject whose data are located in the channel. One is merely required, when plotting a height-weight point in the grid, to read the corresponding developmental level and then to plot this against the subject's age. A series of such points automatically constructs that subject's own auxodrome, which will be found in health to follow the illustrated pattern quite faithfully.[14a] Failure

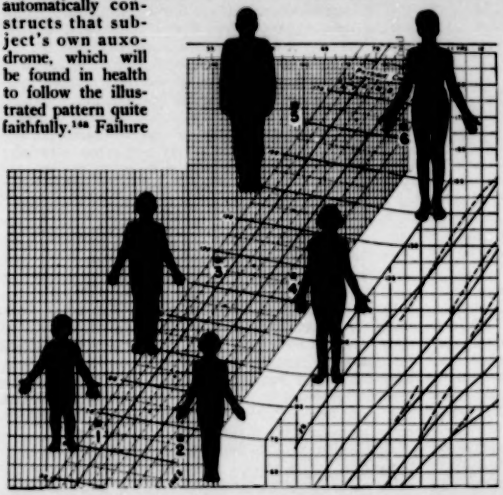

Fig. 7.—Six different subjects with corresponding grid positions, illustrating, in the first place, the difference between stocky and linear types paired at the same developmental level and, in the second place, the constancy of physique for points located at different levels in the same channel. Note that subject 5 is visibly more stout than subjects 1 and 3, the point 5 lying in channel *As*. Note also the identity of the silhouette of subject 3 in this figure with the silhouette in figure 2 at level 118 in *As*.

to do so, as in the case of deviation from the channels, is likewise cause for investigation. The most common abnormal result is the tendency for an auxodrome which has been following one of the more advanced courses to fall behind its expected schedule by a year or more. This may be the first sign of physical trouble and may appear even before the child's developmental curve has departed from its own channel. It signifies that development is being slowed down surreptitiously. Thus, upchannel progress may be considered normal only when it is proceeding at a rate sufficient to maintain advance comparable to that of the standard auxodromes in figure 1.

The significance and mechanism of the age schedules may be brought out by a few examples. Suppose, to begin with, that 2 children are placed on the 100 level line in channel *M*. They will possess the same physique and be at the same developmental level. Their physical status will likewise be the same, namely of "medium build" and "good nutrition." Now they may or may not be of the same age. If they are, and this is 11.6 years, their points will both be on the center auxodrome where the 100 level line intersects the 11.6 year mark. They would, accordingly, be equally advanced with regard to age and they would, for the moment at least, be on the same schedule. If, however, one of the subjects is only 8.35 and the other 14.25 years old, their points will be placed, instead, on the widely separated age schedules represented by the intersection of the 100 level line with the 2 and the 98 per cent auxodromes, respectively. This would indicate a difference of almost six years in relative advancement between them, the former being about three and five-tenths years in advance of "normal," the latter about two and five-tenths years retarded as compared with the "normal" 67 per cent curve.

Developmental Age.—An alternative method of estimating relative advancement or retardation is to determine a subject's developmental age. This is obtained at once by reading the age at which the 67 per cent norm intersects a given developmental level. For example, the child whose level was previously stated to be 100 at 8.35 years by actual age is said to possess a developmental age of 11.6 years. Similarly, a level of 130 attained at 15.3 years corresponds to a developmental age of 13.7 years. The former child is advanced, the latter retarded in development.

This method of assessing development is comparable in some respects to, and serves the purpose of, determinations of skeletal age. It is, however, much simpler, entirely objective, less time consuming and less expensive. In short, it avoids the disadvantages connected with roentgenologic determinations of skeletal age.

Maturation.—The onset of puberty is usually a perfectly definite and recognizable event, by long experience awaited between the twelfth and sixteenth years. Individual variations, especially when the onset seems premature or too long delayed, may be a source of concern. The average age at onset, as indicated in an earlier paper,[10] is remarkably close to 13.6 years for both sexes. This estimate was fixed by the age at which the final deceleration of growth in weight had been found to reach its maximum value. Reports which Greulich [15] has collected give almost exactly the same average age. Concerning individual differences, on the other hand, Shuttleworth [16] has found that girls who mature early are significantly larger than girls of the same age who mature late. By the grid technic this means that girls on the advanced auxodromes tend to mature earlier than those on late schedules. In fact, a study of the question shows that the auxodromes of figure 1 are quite reliable in predicting the onset of menarche. The rule is that this may be expected in the neighborhood of the greatest upper curvature. Puberty in boys is similarly to be expected on their own curves. The greatest upper curvature, moreover, occurs at the very age at which the final deceleration of development is maximum. These results suggest that

14a. See, for example, the two sets of data charted in figure 1.

15. Greulich, W. W.: Some Anatomical Aspects, in A Handbook of Methods for the Study of Adolescent Children, Monographs Soc. Research in Child Dev., 1938, vol. 3, no. 2, pt. 1, p. 53.

16. Shuttleworth, F. K.: Sexual Maturation and the Physical Growth of Girls Age Six to Nineteen, Monographs Soc. Research in Child Dev., 1937, vol. 2, no. 5.

maturation is not directly related to age or to size but rather to a more fundamental and critical property, namely maximum deceleration of growth and development and through this, only indirectly, to age.

Basal Heat Production.—Owing largely to technical difficulties in obtaining satisfactory metabolism tests, the determination of basal heat production has been limited in practice almost entirely to those subjects suspected of disease. But aside from the very real difficulties in getting basal and hence comparable records, another drawback has been the disturbing number of discrepancies among a variety of standards about which there has been almost endless dispute.

The new standards of basal heat production erected on the right hand scale in figure 1 and alined directly to developmental levels are included in the grid technic of evaluating physical fitness for three main reasons: (1) because of the utter simplicity by which estimates of metabolism may now be made, without correcting for body size, physique or age, the only step required being to read the value of heat output that corresponds to the developmental level in question; (2) because of the extremely important advantage of being thus enabled to check pure physical development by entirely independent physiologic measurements of daily energy turnover and vice versa, and (3) because these standards, based on developmental level, can be shown to possess a coefficient of variation as small as, or even smaller than, those of other methods of estimating basal metabolism from the physical measurements of human subjects.

A more complete discussion concerning the theoretical aspects of this problem, with special reference to the derivation of the present standards, will be given in a forthcoming paper. Here it is sufficient to state that they have been adequately tested out against many individual sets of observations, including, besides my own, those reported by Lewis,[17] de Bruin,[18] McKay,[19] Stark,[20] Newburgh,[21] Talbot, Wilson and Worcester [22] and others.[23] A single example may be briefly cited: In two hundred and seventy-one tests on 41 girls between the ages of 2 and 12 years, Lewis found the mean coefficient of variation of heat output in calories per hour referred to weight to be 4.9 per cent; all the other six methods he used to express metabolism gave values higher than this. For the same group of girls the grid method of determining their basal heat production from their developmental levels gives a coefficient of variation of 4.6 per cent. This figure is just slightly below Lewis's but far below the 11 per cent variation reported by Talbot and his co-workers,[22] who also, however, found their own group of subjects to be "internally" more variable than others whom they examined.

The present method, accordingly, offers the encouragement that clinical distinction between normal and abnormal states of metabolism can be made with greater accuracy and less uncertainty than before.

A final point may be mentioned briefly. Basal heat production as here alined to and estimated from the developmental level alone, without correction of any kind, is wholly independent of a child's physique. Specifically, several children, each in a different channel, will have the same standard heat production, provided only that they are all on the same developmental level and all in good health. The true significance of this fact is easily arrived at, though it may not be at once apparent. Heat production clearly has little or nothing to do with the bones but is concerned instead with the soft tissues. The bony skeleton occupies the chief place in the list of elements which determine body build. Hence, on a priori grounds physique itself should contribute little or nothing to daily heat production. In this connection it may be recalled that the grid resolves a given point into two components, only one of which is now seen to be concerned with heat production, for no premium is charged to the account of physique nor is any profit rendered to a subject who possesses one rather than another; but there is an unavoidable price that must be paid in real energy for every step of developmental advancement, and that price is the same for all subjects of the same sex.

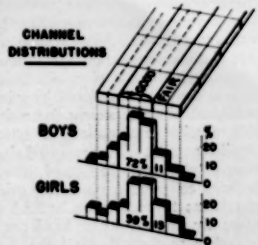

Fig. 8.—Frequency distributions of 4,045 individual children with respect to physical status (compare with table 2). The distribution again represents that at developmental level 100. Economic tenth = 5.3. All children had 6 to 12 year records.

Daily Caloric Intake.—The scales for basal heat production also serve as a practical guide for estimating the daily caloric intake. This figure is always required for computing diabetic, ketogenic, reducing and other special diets, though it is often neglected in the control of normal or regular diets. To obtain the maximum daily caloric intake for either sex at any developmental level one has merely to multiply the corresponding basal heat value by 2. Average values such as those given in the White House Conference Reports [24] are, of course, somewhat lower, the factor being 1.9 for boys and 1.8 for girls. The 10, 20, 30 and 50 per cent above basal values used in calculating reducing diets are likewise easily computed.

Measurements.—Circumstances do not always permit net weight and height to be measured. It is therefore another advantage of the grid technic that any method of taking height

17. Lewis, R. C.; Kinsman, Gladys M., and Iliff, Alberta: The Basal Metabolism of Normal Boys and Girls from Two to Twelve Years Old, Inclusive, Am. J. Dis. Child. **53**: 348 (Jan., pt. 2) 1937.

18. de Bruin, M.: Metabolic Rate in Children with Abnormal Bodily Dimensions, Am. J. Dis. Child. **57**: 29 (Jan.) 1939.

19. McKay, Hughina: Basal Metabolism of Young Women, Ohio Agric. Exper. Station (Wooster), Bull. 465, November 1930.

20. Stark, Marian E.: Standards for Predicting Basal Metabolism: I. Prediction for Girls from 17 to 21, J. Nutrition **6**: 11 (Jan.) 1933; Standards for Predicting Basal Metabolism in the Immediate Pre-Adult Years, Am. J. Physiol. **3**: 630 (April) 1935.

21. Newburgh, L. H.: The Importance of Actually Measuring the Total Heat Production, Ann. Int. Med. **8**: 459 (Oct.) 1934.

22. Talbot, F. B.; Wilson, E. B., and Worcester, Jane: Basal Metabolism of Girls: Physiologic Background and Application of Standards, Am. J. Dis. Child. **53**: 273 (Jan., pt. 2) 1937.

23. These include:
Benedict, F. G., and Talbot, F. B.: Metabolism and Growth from Birth to Puberty, Carnegie Institution of Washington, Pub. 302, 1921.
Du Bois, E. F.: Recent Advances in the Study of Basal Metabolism, J. Nutrition **3**: 217 (Sept.), 331 (Nov.) 1930.
Harris, J. A., and Benedict, F. G.: A Biometric Study of Basal Metabolism in Man, Carnegie Institution of Washington, Pub. 279, 1919.
Lucas, W. P., and Pryor, Helen B.: The Body Build Factor in the Basal Metabolism of Children, Am. J. Dis. Child. **46**: 941 (Nov., pt. 1) 1933.
Nakagawa, Itsiro: Growth and Metabolism, Am. J. Dis. Child. **47**: 963 (May) 1934; **48**: 35, 39 (July) 1934; **49**: 1232 (May) 1935.
Pi-Suñer, J.: Studies in Racial Metabolism: Basal Metabolism of the Araucanian Mapuches, Am. J. Physiol. **105**: 383 (Aug.) 1933.
Topper, Anne, and Mulier, Hannah: Basal Metabolism of Normal Children: The Puberty Reaction, Am. J. Dis. Child. **43**: 327 (Feb.) 1932.
Wang, C. C., and Hawks, J. E.: Basal Metabolism of Twenty-One Chinese Children Reared or Born and Reared in the United States, Am. J. Dis. Child. **44**: 69 (July) 1932.

24. The Energy Requirements of Children After Infancy; in Growth and Development of the Child: Part III. Nutrition, Reports of the White House Conference on Child Health and Protection, New York, Century Company, 1932, pp. 409-420.

and weight, consistently employed and suitable to the scene of examination, may be used, for the effect of indoor clothes plus shoes is merely to displace true net values along the same channel by approximately 3 to 5 units, because clothes weight is compensated by moderate heel height.

No measurements other than those of weight, height and age are required. These, moreover, may be taken in either metric or customary systems with identical results. A child's body build or physical or nutritional status should not be made to depend on the purely arbitrary choice of units of measurement, as has so frequently been the case. This defect invalidates much previous work on the subject. Body build is the same whether it is measured by meter rule or yardstick.

Other measurements, viz. iliac (bicristal) diameter, chest circumference, bisacromial width, sitting height, are not needed in the present method, since the grid with benefit of height-weight data alone is sufficiently sensitive for clinical purposes to detect measurable changes in physique.

It should be emphasized, finally, that the usual accidental variations in measurements of this kind are allowed for by channel width and that any difference greater than one-half channel per 10 units of advancement must be regarded as systematic until proved otherwise.

STATISTICAL BACKGROUND OF THE GRID TECHNIC

The grid has been tested in a number of ways. In the first place more than twenty-five thousand paired sets of measurements on 4,000 children have been individually analyzed. Among these were twelve thousand sets of measurements on 2,093 Cleveland school children whose grid ratings of physical status were compared with clinical appraisals rendered by school physicians.[25] No published records, except for a few examples, supply this crucial combination of observations. While a detailed account will be reported elsewhere, a few important results may be stated here. Gross agreement between estimates made by the grid and those made by physicians turned out to be 87.5 per cent, which significantly exceeds the 60 to 65 per cent figure reported by other workers.[26] Half the discrepancies occurred among children whose curves and points fell into the B_2 (fair) channel. These are the children on whom physicians themselves find it difficult to agree in more than 50 per cent of cases. Consequently, agreement between the grid and physicians on subjects in all the other channels rose to 94.5 per cent.

Of 205 children called "poor" by physicians, 203 were caught by the grid as unsatisfactory, either because of unfavorable channel position (table 2), excessive change in channel between successive measurements, age retardation or objectionable progress. Again, of 371 subjects called "poor" or "borderline" by physicians, the grid caught 350, or 94.5 per cent. In other words, the grid may be depended on to select those subjects in the obese, fair, borderline and poor groups whom physicians themselves consider to be in need of more intensive examination than that afforded by routine check-up. Of special importance is the fact that the grid identifies those children who are "not doing so well as might be," even though they are placed at the moment, as regards their physical status, in the channels called "good."[26a]

As a further check, the grid method has been tested on the voluminous data reported from the Materials of the Harvard Growth Study by Dearborn and his co-workers,[27] on the data of several smaller series[28] and finally against the mean values of more than 400 reports in the literature dealing with growth and nutrition of large groups of children under various conditions.

The frequency distributions of physical status, as defined by the grid method, are almost identical for all reports thus far examined, and they compare with the distributions given in table 2 and figure 8. Differences between groups can be explained by differences in socioeconomic and racial factors. Broadly speaking, 15 to 25 per cent of boys and 30 to 35 per cent of girls are today definitely in need of medical supervision and care; the majority of these are under par, the remainder obese. The unfavorable position of girls in both obese and under par classes is a continually recurring result and merits closer investigation.

COMMENT

The grid technic of evaluating physical fitness has been designed to serve a number of different purposes and to fulfil certain long felt needs. Its chief purpose is to aid a medical examiner in rendering a more objective opinion than would otherwise be possible on the physical condition of a given subject. It is intended to be used as a record of and as a guide to individual progress throughout the entire range of adolescence from infancy well into maturity.

Simplicity of operation has been a main objective; another object has been to achieve maximum returns for a minimum of effort and time, without sacrifice in accuracy or dependability. The required steps, entries and items of analysis have been limited wholly to those considered necessary and sufficient for a grid rating of physical fitness. To facilitate actual work with the grid, a three color design (9 by 11½ inches) is now in preparation.

The amount of information which the grid recovers from a given set of observations that are ordinarily disregarded as soon as they have been made is obviously great. The results, moreover, can be obtained with no more expenditure of time or effort than that required to plot two points and to sight on a third. They constitute a quantitative rating of physical fitness which is independent of any bias traceable to the subject, to physicians or to the circumstances of examination, and they may be compared directly with the clinical estimate.

Aside from its usefulness in private practice, the grid is especially suitable whenever large groups of children must be dealt with. From the standpoint of public and school health, it appears that about 30 per cent of children are definitely in need of very careful medical attention. Yet, owing to lack of time and funds, no medical staff can possibly examine all its children at close intervals to detect those who require continued observation, examination and advice. The unfortunate result is that much trouble is not recognized until it

25. Dr. Harold J. Knapp, commissioner of health, and Dr. J. I. Hartman, supervisor of medical inspection of the Board of Education of the City of Cleveland, and members of their respective staffs made the study possible by providing what was essential, namely, simultaneous records of clinical appraisal along with the physical measurements of each child.

26. Franzen.[9] Jones.[9]

26a. E. g., by a shift from channel A_1 to B_1 or from one age schedule to another.

27. Dearborn, W. F.; Rothney, J. W. M., and Shuttleworth, F. K.: Data on the Growth of Public School Children (from the Materials of the Harvard Growth Study), Monographs Soc. Research in Child. Dev., 1938, vol. 3, no. 1.

28. Davenport, C. B.; Renfroe, O., and Hallock, W. D.: The Relation Between Change in Basal Metabolism and Growth During Adolescence, Child Dev. 10:181 (Sept.) 1939. Espenschade, A.: Motor Performance in Adolescence Including the Study of Relationships with Measures of Physical Growth and Maturity, Monographs Soc. Research in Child Dev., 1940, vol. 5, no. 1. Zeitharn, C. E.: Data to be published.

has become unnecessarily far advanced. The present scheme provides a simple technic for screening children whose physical condition is presumably under par or whose progress and development are not satisfactory. The important practical result is that the work of medical staffs in connection with child health programs can be made more efficient. With the grid record of each child before him, the physician will be enabled to devote more effort to those children who actually require attention, instead of being burdened 70 per cent of the time with searching for possible defects among children whose progress and physical condition are in reality up to acceptable standards.

Two important side effects are assured. First, those children selected by their own grid records may be immediately placed under remedial control; second, a more accurate estimate of the extent and distribution of malnutrition in any community will be available to authorities. In all events the advantages traceable to early identification of unsatisfactory physical state and progress are self evident.

A warning note may be sounded. From one point of view the grid technic is almost too simple. Widespread interest in personal health might entice unqualified "observers" to render judgments otherwise unavailable to them. The grid, however, gives information on, and only on, the items explicitly listed in table 1. Specific pathologic events are entirely outside its field. A brain tumor, or many another disease, can appear in a subject of most excellent physical build. Consequently, it must be finally emphasized that the interpretation of the curves lies solely within the province of the physician, who can take the results of his own examination and the grid rating into joint account.

SUMMARY

1. A simple, objective method for evaluating physical fitness is based on the use of a grid devised for this purpose.

2. To establish a grid rating of physical condition, only three traditional measurements (weight, height and age) are required. When these are plotted on the grid, direct estimates of physique (body build), developmental level, nutritional grade, physical status and relative age advancement are obtained independently of one another. For successive annual or semiannual observations a record is built up which shows how satisfactory progress has been in the past and also indicates what forthcoming progress may be expected in the near and more distant future.

3. The grid consists of seven principal channels, the axes of which, taken crosswise, cover a range of physique (body build) from the obese to the extremely slender type and, channelwise, a range of development from infancy to maturity. The paths are linear during school life.

4. Healthy developmental progress continues in an established channel as though this were a preferred path; channel width accounts for accidental variation which does not exceed one-half channel per 10 units of advancement. Channelwise progress indicates development with preservation of given physique; cross channel progress is accompanied by change in physique. The latter type, sufficiently continued, culminates in a pathologic state. An upward trend greater than that of the channel slope indicates that obesity is in the making; a downward trend less than that of the channel system suggests that "malnutrition" is not far removed.

5. The slope or gradient of the developmental curve gives a simple and direct measure of what clinicians, in assessing physical fitness, call the state of nutrition. Optimum nutrition, overnutrition and undernutrition are presumptively indicated by zero, positive and negative departures, respectively, from the channel slope.

6. Physical status is the attribute which results from the combined effects of growth, development and nutrition cumulated to the moment in question. Six ratings are tabulated to identify subjects in the obese, stocky, good, fair, borderline and poor groups.

7. Standard schedules of developmental progress (auxodromes) are given which show how far the physically advanced, regular or retarded child may be expected to have developed at a given age. Average progress is approximately one level line a month. Values much greater or less than this are unsatisfactory, even though development is proceeding strictly at the channel slope.

8. Maturation for both boys and girls may be expected at the age when their own auxodromes undergo the greatest curvature and thus at the time when deceleration of development is maximum.

9. An alternative method of estimating relative advancement or retardation is to determine a subject's developmental age. This serves the same purpose as, but avoids the disadvantages connected with, roentgenologic determinations of skeletal age.

10. New standards of basal heat production are included which enable estimates of metabolism to be made, without further correction, from the developmental level attained by a given subject.

11. The heat production scale in conjunction with developmental levels also provides a ready estimate of the daily caloric intake required in regular and special diets.

12. By actual test, grid ratings of physical fitness on 2,093 school children have been compared with physicians' estimates. Agreement reached 94 per cent for all children except those in the B_2 (fair) channel, on whom physicians find it difficult to agree among themselves. The grid, moreover, caught 94.5 per cent of the subjects called "poor" or "borderline" by the physicians. Today approximately 30 per cent of all children are in need of more than routine check-up. The screening and identification of these particular children are greatly facilitated and reliably performed by simple inspection of their grid records. But final judgment on their physical fitness rests with the physician, who can take both the grid and the clinical results into joint account.

2103 Adelbert Road.

Personal Improvement of Health.—Many persons fail to understand that the quality of health may be improved. They live without personal effort to enrich their lives. On the contrary, every intelligent person should have the desire to take charge of his life and to make himself as efficient as possible. Such advice is not directed at those who are ill. It is meant to apply especially to those who are not sick, because even the well, by better living, can attain an increased strength. No experiment in the laboratory of the school is half as fascinating as this one of personal improvement.—Williams, Jesse Feiring: Healthful Living, New York, Macmillan Company, 1941.

A SIMPLIFIED CITRATE-DEXTROSE BLOOD PRESERVATIVE

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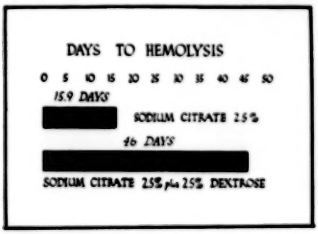
In the Oct. 14, 1939 issue of THE JOURNAL the Transfusion Service of the Massachusetts Memorial Hospitals, Boston, reported on "The Use of Placental Blood for Transfusion."[1] This article emphasized among other things the advantage obtained by the addition of dextrose to the preservative. We reported that the addition of dextrose retarded hemolysis from fourteen and four-tenths days to twenty-two and three-tenths days. This same paper stated that we were confident a series of blood specimens then being studied would show an even more delayed hemolysis. It is on this series of 250 blood specimens that we are now reporting.

The Rous and Turner[2] solution consisting of dextrose, citrate and blood, as described by Robertson,[3] was efficacious in delaying hemolysis. There were two outstanding disadvantages in their technic: (1) the large amount of preservative that was required; (2) the concentration of sodium citrate in the mixture,



Advantage of sodium citrate 2.5 per cent plus 5 per cent dextrose over sodium citrate 2.5 per cent.

which was too high for safe intravenous administration. These factors necessitated the discarding of the supernatant plasma and the transfusing of the cells suspended in saline solution. DeGowin and his co-workers[4] modified the original Rous and Turner solution, reducing the concentration of citrate so that the modified mixture could be transfused without discarding the plasma. In our original work on placental blood we used the so-called Moscow solution, adding varying amounts of dextrose in an attempt to simplify the Rous and Turner procedure. As our work on preservatives advanced we discarded the Moscow solution for 2.5 per cent sodium citrate, adding 5 per cent dextrose. The citrate-dextrose solution retarded hemolysis ten and eight-tenths days longer than the Moscow dextrose solution. With these results in mind we began a series using fresh venous blood in April 1939.

We standardized our work and equipment. One operator was responsible for collecting the blood, and one technician was responsible for the laboratory work required in preserving the blood. A closed method of collection was adopted. The blood was stored in the same type of container (Fennell flask), and at a constant temperature of 38 C. All flasks were stoppered with air-tight rubber Stazon stoppers. Care was taken not to agitate the flasks, and the flasks were not exposed to direct sunlight, the supernatant fluid of the flasks was inspected daily and beginning hemolysis was recorded on the day when a faint pinkish tint was demonstrated. The only variable factor was the percentage of dextrose. As a control we preserved every third flask with 2.5 per cent sodium citrate. The amount of blood preserved in each case was 500 cc.

Fifty flasks of fresh venous blood were preserved by means of sodium citrate 2.5 per cent with dextrose 0.5 per cent. The average number of days to the appearance of hemolysis in this series was twenty-one and five-tenths days.

Following this series of fifty flasks of 0.5 per cent dextrose and 2.5 per cent citrate we preserved six flasks of 1 per cent dextrose with citrate, six flasks of 1.5 per cent dextrose and citrate and so on up to 2.5 per cent dextrose.

In a series of 92 bloods preserved with 2.5 per cent sodium citrate and dextrose 2.5 per cent the average number of days to the appearance of hemolysis was forty-six.

In a series of 84 bloods in which 2.5 per cent sodium citrate was used as a control the average number of days to the appearance of hemolysis was fifteen and nine-tenths.

In the beginning of our experiment we encountered immediate hemolysis on the addition of the citrate-dextrose mixture. At that time the citrate-dextrose mixture was packaged in an amber colored bottle[5] with a soft rubber stopper. The citrate-dextrose solution was drawn through the needle and tubing of our collecting apparatus into the flask. A venipuncture was then performed, and by negative pressure the blood flowed into the flask containing the preservative. Apparently immediate hemolysis occurred when the first blood came in contact with the high concentration of dextrose. Our technic was changed, citrate was placed in the flask, 500 cc. of blood was collected and then 25 cc. of 50 per cent solution of dextrose with 25 cc. of sterile distilled water was carefully added. This simple modification of technic prevented further difficulties. The flasks were inspected daily for beginning hemolysis, and if hemolysis was observed even before the date of expiration the flask was immediately removed and forwarded to the laboratory for conversion into plasma. We have arbitrarily chosen eight days as the date of expiration for flasks preserved with sodium citrate. Likewise we have arbitrarily chosen twenty-one days as the date of expiration for flasks preserved with dextrose and citrate.

In May and June 1939 we took cultures of the flasks for contamination. Contamination was not encountered, and it is a policy now to take cultures only of the flasks that have been opened for one reason or another. Cultures are taken on all flasks of plasma.

Reactions following transfusions in which the citrate-dextrose solution preserved twenty-one days was used have been no greater than when blood preserved with citrate for eight days was used. A slight febrile reaction has been encountered in 2 per cent of all trans-

From the Transfusion Service, Department of Surgery of the Massachusetts Memorial Hospitals.

1. Barton, F. E., and Hearne, T. M.: The Use of Placental Blood for Transfusion, J. A. M. A. **113**: 1475-1478 (Oct. 14) 1939.
2. Rous, Peyton, and Turner, J. R.: J. Exper. Med. **23**: 219 (Feb.) 1916.
3. Robertson, O. H.: Transfusion with Preserved Red Blood Cells, Brit. M. J. **1**: 691 (June 22) 1918; personal communication to the author.
4. DeGowin, E. L.; Harris, J. E., and Plass, E. D.: Studies on Preserved Human Blood: I. Various Factors Influencing Hemolysis, J. A. M. A. **114**: 850-855 (March 9) 1940.

5. Furnished through the courtesy of the Alba Pharmaceutical Company for experimental purposes.

fusions, with no deaths. No difficulties have arisen from the diffusion of potassium, and the clinical response following the transfusion of blood preserved with the citrate-dextrose solution has been entirely acceptable. It is extremely simple to carry out the procedure outlined. It does not require added space for storage. We believe that this method of preservation of blood has a distinct advantage for a small bank.

SUMMARY

A technic of preserving blood by the use of a simplified citrate-dextrose solution was adopted.

Fifty flasks preserved with sodium citrate 2.5 per cent and dextrose 0.5 per cent failed to show hemolysis for twenty-one days.

Ninety-two flasks preserved with sodium citrate and dextrose 2.5 per cent failed to show hemolysis for forty-six days.

Eighty-four flasks with sodium citrate 2.5 per cent used as a control showed hemolysis in fifteen days.

Blood preserved with the citrate-dextrose solution has been used clinically with good results.

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TREATMENT OF THE MENOPAUSE

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MADISON, WIS.

Although clinicians generally are convinced of the value of estrogenic substances for the relief of the protean symptoms of the climacteric period in women, there is much uncertainty about the optimal preparation. The choice must be made among three distinct estrogenic compounds and mixtures of these with other less potent substances. Unstandardized preparations of ovary may give clinical results, but the benefits are too uncertain to justify the employment of these early types of medication any longer. The choice between pure compounds such as estrone or estradiol and mixtures in which estrone is the chief ingredient depends on two factors: price and type of result. Except in rare cases the clinical result from any one of this estrogenic group has been found so similar to that of the others that the only important factor is price. But direct comparisons in cost have been impossible for the clinician, since the units employed by manufacturers have not been easily compared. Some preparations are marketed in terms of international units, others of rat units, others of "active biologic units" and "day oral units" and others of milligrams. The weight basis is obviously the best, but it cannot be applied to mixtures of more than one estrogen.[1] This interferes at once with the evaluation of the oldest standardized preparation on the market, which contains several estrogenic substances but chiefly estrone. Furthermore, the weight basis is misleading when applied to estradiol, for in animal assays this is known to be far more active than estrone or estriol. But the comparisons of biologic activity vary significantly, depending on the test which is employed. There is no accepted ratio for comparison of the efficacy of these pure estrogenic molecules in relieving the symptoms of women.

From the point of view of the clinician it seems worth while to establish a comparison of the better known estrogens for women who are suffering from menopausal symptoms. As criteria for the effectiveness of therapy there are two indicators: subjective relief and vaginal epithelial response. The technic for the study of the vagina has been described and validated by Papanicolaou and Shorr.[2] They have shown that the qualitative changes in the appearance of the desquamated vaginal epithelium are proportional to the amount of estrogen acting in the body. This vaginal effect serves to demonstrate the effects of oral as well as parenteral estrogen therapy. By this method the doubts of skeptical clinicians can be satisfied, for relief of symptoms can be shown to parallel objective findings. In this study the two criteria have been used as independent end points in an attempt to "titrate" the evidences of the menopause with a series of estrogenic preparations. The chart of a typical patient will illustrate how this was carried out. The symptom relief was recorded as "excellent," "good," "fair" or "poor" at the time of an office visit and always by the author in person. Vaginal samples were obtained by the well known method, fixed at once in alcohol and ether and read by an especially trained assistant who knew nothing of the patient's report. The readings were not known until some days later. Alterations in dose were ordered according to the symptoms, and the results of microscopic studies used as a check in later study. When these results are plotted on a scale of 1 to 4 plus for the intensity of estrogen action, and the symptom relief similarly, two curves are obtained with surprising parallelism. It is this tendency to parallel variation of the objective changes and symptoms which gives reason for confidence in the comparisons to be made.

Because of the local reactions to oil injections by some patients and the superior type of control obtainable with oral therapy, as well as the greater convenience secured by avoiding injections, all the comparisons to follow were based on oral administration of estrogenic material.[3] Earlier trials of estriol had been far less satisfactory than those with estrone; hence no use of estriol was undertaken.

Late in 1940 the Council on Pharmacy and Chemistry of the American Medical Association adopted the term "estrogenic substance" to refer to naturally occurring mixtures of estrogenic materials. Since more than one estrogenically active compound is present in such mixtures and since potency per milligram varies widely, it is impossible to state potency of such substances in terms other than biologic units. The application of the international unit for pure estrone to such mixtures is far from satisfactory. Attempts to improve this standardization technic are under way in 1941. This should make it possible to check satisfactorily by laboratory methods on the potency for clinical use of the

Publication delayed because of unpreventable complications.

From the State of Wisconsin General Hospital and the Department of Medicine, University of Wisconsin Medical School.

Read before the joint meeting of the Section on Practice of Medicine and the Section on Pharmacology and Therapeutics at the Ninetieth Annual Session of the American Medical Association, St. Louis, May 19, 1939.

1. Pedersen-Bjergaard, Kaj: Comparative Studies Concerning the Strength of Oestrogenic Substances, London, Oxford University Press, 1939.

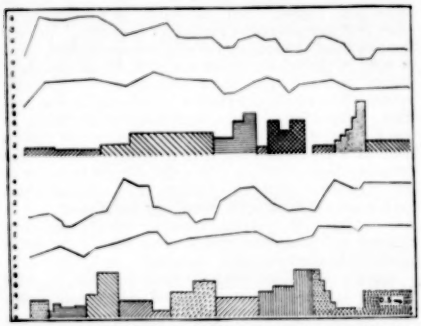
2. Papanicolaou, George, and Shorr, Ephraim: Action of Ovarian Follicular Hormone in the Menopause, as Indicated by Vaginal Smears, Am. J. Obst. & Gynec. **31**: 806 (May) 1936.

3. For this study Schering Corporation supplied estradiol and also some modifications of this compound not yet ready for market release; Ayerst, McKenna and Harrison, estriol glucuronide; Endo Products, Inc., Lakeside Laboratories, Inc., Kremers-Urban Drug Company and E. R. Squibb & Sons supplied estrogenic substances 1, 2, 3 and 4. Special mention should also be made of the estrone supplied by the Abbott Laboratories in capsules for oral use, of the estrone in 90 per cent alcohol prepared by Eli Lilly & Co. and of supplies of stilbestrol from the Squibb and Lakeside laboratories. These special products are not yet to be placed on sale but were compared with the other commercial products mentioned.

numerous brands of estrogenic substances which are appearing on the American market.

One of the results is the demonstration that there are minor variations in the results, objective as well as subjective, when a given dose is used daily by a particular woman. Therefore it would be necessary to keep each patient for several weeks on each dose of each estrogen to be certain of the exact value of that treatment. This method seemed too tedious. Results are therefore presented in terms of a series of comparisons which state that a certain dose of preparation A is better or worse than a definite dose of preparation B. The differences are slight, but they exist, without doubt. In a few cases essential equivalence of result could be read with certainty from the protocols. The comparisons as stated are in terms of the objective changes; that is, the vaginal reactions and not the patients' reports.

Table 1 presents the comparisons of four of the most widely known estrogenic preparations. Results are all calculated to the amounts of estrogenic substance, or estrone, which are compared with 600 active biologic units of estradiol. The actual doses



Comparison of objective and subjective changes in one woman from use of various estrogenic substances. Upper line represents response of vaginal epithelium from 0 (castrate type) to 4 (full estrus smear). Lower line represents subjective relief, e. g. E excellent, G good, F fair, P poor. Doses of estrogens in thousands of units orally a day, estriol glucuronide in tablets, stilbestrol in tenths of milligrams. Time elapsed seventeen months.

varied from 600 to 7,200 such units of estradiol and from 2,000 to 10,000 units of estrogenic substance. There are some variations, but the best statement in summary would be that estradiol is at least three times as potent as estrogenic substance 1, unit for unit. Just here is met the difficulty. The unit of estrogenic substance 1 is the international unit as defined by the League of Nations. The unit of estradiol is an "effective unit" or an active biologic unit as defined by the manufacturer. This unit does not bear a constant relationship to the weight of material in the tablet and depends on a clinical report from one cooperating clinic. The 600 "units" have been claimed for 0.9 mg., more recently for 0.5 mg. Since there can be no rational comparison of such units, it is possible to make this comparison clinically only on a price basis. The quotation to the retail trade as of January 1941 on estradiol containing 600 effective (or active biologic) units per tablet was 14 cents per tablet. That for estrogenic substance in 2,000 international unit capsules was 9.6 cents. The aforementioned 600 and 2,000 unit amounts are as nearly comparable as can be determined from this method of study. It is therefore evident that the price will lead the clinician to choose estrogenic substance 1.

A further factor in making a choice would be any superior type of result due to one product. In general

Table 1.—*Relative Potency of Estrogenic Substances*

Estradiol, 600 Active Biologic Units, was more potent than		
Estrogenic Substance 1	Estrogenic Substance 2	Estrone
2,000 I. U.	5,000 I. U.	3,600 I. U.
2,000	4,800	2,500
2,000	3,000	2,000
1,666	2,500	1,200
1,200	2,000	
833	2,000	
750	2,000	
	or as potent as	
2,000		4,500
666		3,750

all these comparisons have led me to make the statement that any of the estrogens considered can give any degree of control desired, depending entirely on the dose. There have been only two exceptions to this conclusion: In one woman nausea and emesis followed the use of estrogenic substance or of stilbestrol, but results were entirely satisfactory with estradiol. In another the use of estrogenic substance was entirely unsuccessful in the control of hot flashes, whereas comparable doses of estradiol were satisfactory.

Comparisons with estrogenic substance 2 have been surprising. This material is labeled in international units and was expected to be directly comparable to estrogenic substance 1. Table 2 shows it in comparison with estradiol, and the results may be summarized as showing that estradiol is from four to eight times as effective as estrogenic substance 2. Table 2 also shows that estrogenic substance 1 is at least two and a half times as useful as 2. Further comparisons with estrone are available. The latter substance was used in weighed doses. A capsule with 1 mg. of estrone would by definition contain 10,000 international units. Direct comparisons between estrone in milligrams and estrogenic substances 1 and 2 in units cannot be drawn from the protocols. Indirect comparisons of each with the nearest equivalent doses of estradiol suggest that estrone and estrogenic substance 3 are both inferior to estrogenic substance 1 unit for unit. In this case the units are the same. This comparison can hardly be final, but it suggests that the mixture of estrogens 1 is more effec-

Table 2.—*Relative Potency of Estrogens*

Estrogenic Substance 2, 1,000 I. U., was less potent than		
Estrogenic Substance 1	Estrone	Estradiol
400 I. U.	1,250 I. U.	120 A. B. U.
415	1,250	125
	1,800	200
	2,000	240
		300

tive in the human being than its potency in international units based on estrus production in the rat would indicate. There will remain some uncertainty about the significance of these comparisons of two brands of estrogenic substance until the exact chemical composition of each is known and the purity of estrone certified. Estrogenic substances 1 and 3 appeared directly comparable, unit for unit.

V 19

Table 3 presents a series of statements about estriol glucuronide. This material, derived from the placenta, is a mixture of estrogenically active substances. It is standardized not in international units but in day oral units, 120 to each tablet. Again it would have to be compared on a price basis. The most recent quotations on estriol glucuronide are 3.7 cents per tablet of 120 day oral units. The comparison is therefore that for 3.7 cents one can secure less help with estriol glucuronide than for 1.07 cents with estrogenic substance 1 or for 3.1 cents with estradiol. Furthermore, it will be noted that doses of 6 to 9 tablets of estriol glucuronide were required, with less benefit than was obtained from small doses of the other estrogens. Because of the large doses sometimes required, i. e. from 10,000 to 20,000 units daily in cases of severe involvement, it becomes manifestly impossible to use estriol glucuronide in the more extremely disturbed menopausal patients, as the manufacturers have stated frankly. Recent trials of 600 and 1,200 unit tablets

TABLE 3.—*Relative Potency of Estriol Glucuronide*

Estriol Glucuronide 1 tablet or 1 teaspoon (120 day oral units) was less potent than		
Estrogenic Substance 1	Estrone	Estradiol
222 I. U.	1,000 I. U.	133 A. B. U.
333	1,000	

TABLE 4.—*Relative Potency of Estrogens*

Estrogenic Substance 1, 2,000 I. U., as potent as		less potent than
Estrone	Estradiol	Estradiol
3,750 I. U.	600 A. B. U.	600 A. B. U.
	1,800	600
		600
		720
		1,200
		1,440
more potent than Estriol Glucuronide (120 oral units) 6 or 9 tablets		

indicated a wider usefulness for these more potent tablets.

One of the surprising results has been the demonstration that estrone can be applied on the skin in alcohol solution and that there is prompt and efficient absorption of the estrogen, while the alcohol evaporates quickly. I have repeatedly demonstrated that this method will control climacteric symptoms satisfactorily. In 1 case in which daily intramuscular administration of 10,000 unit doses of estrogenic substance 1 had long been given it was possible to transfer to the same dose of 10,000 units of estrone in alcohol on the skin. Later, as is the case with oral therapy, the dose was gradually reduced with continued control of symptoms. In another case daily administration of 4,000 units in oil given intramuscularly was replaced by 4,000 units on the skin. The first patient had been castrated by irradiation several years previously because of neurofibroma in the femur, which also led to a high amputation of the thigh. The daily use of large doses of an estrogen had been necessary to control extraordinarily severe pain and nervousness associated with a neuroma in the stump. The application of from 5,000 to 10,000 units of estrogen daily to the skin of the abdomen for more than twenty-eight months has led to no sign of any dermal change. Occurring in a woman with a known history of tumors, this is rather reassuring. The possibilities of surface application of estrogen are encouraging because of ease of application, ease with which the dose can be measured and greater efficiency per unit than in any other route of administration save that by oil injection. Eli Lilly & Co., which furnished the material, is not prepared to release this solution. Brief experience with estradiol in alcohol demonstrates it to be absorbed through the skin likewise.

Recently the trials of stilbestrol have been compared with the results from estrone and estradiol. The preliminary results suggest that stilbestrol must be approximately as potent orally as estrone when compared on a weight basis. The oral use of estradiol is inefficient, as a consequence of which the doses of stilbestrol are much smaller in milligrams than those of estradiol. The reports of nausea from stilbestrol can be confirmed for a few patients, but in all save 2 it has been easy to secure relief from symptoms of the climacteric with doses small enough not to cause gastric distress. There have been no other unpleasant effects from stilbestrol. Since this compound is a synthetic substance, without known biologic effects other than its estrogenic action, it probably ought not to be introduced into general clinical use until more extensive toxicologic studies have been reported. It is not at present available for sale in the United States.

In conclusion there is one further observation of clinical significance. The foregoing comparisons were all made on the basis of the objective data from vaginal epithelium. If the subjective relief curves had been used, the advantage of estrogenic substances and even estriol glucuronide would have been slightly greater. In other words, there were numerous occasions when patients were better satisfied than the vaginal cell response would suggest. The differences between the two criteria were not great, but they occurred frequently enough to call attention to their direction.

It is evident that estrogenic therapy by the oral route is dependable. The choice of preparation to be used is largely a matter of price, save that estriol glucuronide is not practical in large doses. Comparisons of units are still difficult unless one is dealing with identical chemical compounds. The mixed estrogens known now as estrogenic substances and estriol glucuronide appear to have an advantage per unit over the pure estrone, which is the chief constituent of the mixture. Estradiol is not better clinically and suffers from the price comparison. If this can be adjusted, the clinician may use whichever preparation he prefers and secure equally good control of climacteric symptoms.

Four Years Short of New Zealand.—In the sixteenth century the average length of life in western Europe is said to have been nineteen years; in the seventeenth century, twenty-five years; in the eighteenth century, thirty-two years. In the nineteenth century in this country life averaged approximately forty years; at the beginning of the present century this average had increased to forty-nine years, and by the end of the first quarter of the twentieth century to approximately fifty-seven years for boys and to approximately sixty years for girls. By 1938 this increase in life expectancy at birth in the United States had extended to sixty-two years for males and females combined. Splendid as this is, it is still four years short of the present life expectancy in New Zealand.—Diehl, Harold S.: Healthful Living, New York, McGraw-Hill Book Company, Inc., 1941.

ACCIDENTAL TRANSMISSION OF MALARIA

THROUGH ADMINISTRATION OF STORED BLOOD

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In 1938 Wright[1] published an excellent review in which he collected 24 case reports of accidental transmission of malaria through the administration of blood. To this he added 6 cases of his own. Since 1938, 5 other cases covering this subject have been described by McCulloch,[2] Gardner and Dexter,[3] Zussman and Silver,[4] Nabarro and Edward[5] and Chamorro and Molezzun.[6] In all these cases the blood used for the recipient was freshly drawn from the donor and given shortly afterward either intravenously or intramuscularly.

The case about to be related is probably the first ever to be reported in which malaria was acquired through the transfusion of stored blood obtained from a blood bank. As careful a search as it was possible for me to make failed to uncover any like report.

REPORT OF CASE

M. C., a 7 year old white boy of Irish-American parentage, was admitted to the pediatric service of the Yonkers Professional Hospital on March 6, 1940 because of an unexplained fever of three months' duration.

The patient's past history revealed nothing of importance up to Oct. 25, 1939. On this date he was admitted to a hospital because of burns involving the left side of the head and the left upper and lower extremities. He remained in the hospital nine weeks, during which time the burns responded to treatment except for a small area behind the left ear which became secondarily infected. He had a high continuous fever for the first four weeks, and three blood cultures taken at various times in this period were negative except for the initial one. This yielded a staphylococcus producing a small amount of yellow pigment and a slight zone of hemolysis. The impression then was that the culture had become contaminated.

The hematologic examination on admission was normal, but in the course of nineteen days moderate secondary anemia developed. Because the boy was seemingly losing ground he was given blood transfusions on November 11, 19 and 22 of 300 cc., 300 cc. and 250 cc. respectively. The blood was obtained from the blood bank maintained by the hospital. Two different donors were used. Unfortunately it could not be determined how many times each person's blood was given.

During the last five weeks that the patient was hospitalized his progress was one of slow but steady improvement, and he continued to be afebrile and asymptomatic.

Following his discharge on December 23 he was seen in the surgical outpatient department on several occasions. On Jan. 29, 1940 the mother told the attending physician that her son was having recurrent attacks of fever, and because there was no apparent explanation for it he was referred to the pediatric clinic. The appointment was not kept.

The story from that time until his present admission, as obtained from the mother, was that on December 25, two days after discharge, the boy began to have a high temperature. Bouts of fever were noted to have made their appearance once a week up to a month prior to admission, after which they recurred twice a week. On one occasion the temperature was taken and found to be 106 F. Frequently there was a chill just before the fever reached its peak, and sometimes vomiting occurred at the height of the fever. Jaundice was never observed, and at no time did the patient complain of abdominal discomfort. Urologic symptoms were also absent.

When the patient was admitted to the pediatric ward his rectal temperature was 99 F., pulse rate 110 and respiratory rate 25. He was very thin, poorly developed and malnourished but did not appear to be very sick. The positive manifestations were limited to the left mastoid region, where the skin had been burned and had not entirely healed. There was no edema of the tissues and no pain. Some crusting of the burn was evident. The left leg was rather badly scarred but completely healed. The spleen was not palpable at this time, though the tip of it could be felt at times later on.

Urinalysis disclosed a faint trace of albumin and rare hyaline and granular casts. The red cell count was 3,120,000 per cubic millimeter, with hemoglobin 56 per cent (Sahli); the white cells numbered 6,500 per cubic millimeter with 65 per cent polymorphonuclear leukocytes. The stained smear showed evidences of moderately severe secondary anemia. The Wassermann reaction was negative.

The patient's chart illustrates his progress in the hospital.

At first osteomyelitis of the mastoid process was considered to be the cause of the fever, but roentgenograms failed to reveal any bony changes. Two blood cultures taken during the second and third peaks did not yield any organisms. Agglutination tests for typhoid, paratyphoid and undulant fevers all gave negative results.

After my observing the patient closely for ten days, during which time he had three febrile episodes regularly spaced by intervals of two days, the cause of these rises was suspected. Clinically, the patient did not seem to be much affected by them. He appeared rather listless, but he did not vomit and had no chills. It occurred to me that the boy might have malaria. Accordingly, on the morning of March 16, a few hours before the anticipated rise, thick drop preparations of his blood were made. The smears were stained by the Giemsa method and examined by Dr. H. K. Russell, director of the hospital laboratory. Quartan malaria schizonts were found in fair numbers by him.

Treatment with atabrine, 0.1 Gm. twice a day, was begun on March 18 and continued for five days. On March 19 the patient was given a transfusion of 250 cc. of citrated blood, his father acting as donor. A few hours later, the temperature rose suddenly to 107 F. and the patient had a severe shaking chill lasting an hour. The next day the boy was moderately jaundiced and the spleen was palpable. He voided a bloody urine which gave a positive benzidine reaction. Microscopically, no formed elements were found; the lack of them thus confirmed the diagnosis that the patient had suffered from an acute attack of paroxysmal hemoglobinuria. At the end of ten days the jaundice had cleared up and the urine showed no blood. A recheck on the recipient's and donor's blood was made, and they were again found compatible.

On March 26 the temperature went to 101.4 F., and it was felt that another course of atabrine was indicated. This was begun the next day and continued, as before, for five days. Soon afterward the temperature dropped to normal and remained so to the time of discharge. Smears of the patient's blood were taken almost daily after the diagnosis was made, and March 22 was the last date that any parasites were found.

The boy's appetite during the last three weeks of his stay became enormous. He gained in weight and improved in every other respect. The diet was reinforced with 9 grains (0.6 Gm.) of ferrous sulfate and 500 international units of thiamine hydrochloride daily. The red cell count on discharge was 3,530,000 and the hemoglobin 77 per cent (Sahli).

As soon as the diagnosis of quartan malaria was made the problem of discovering the source of the infection immediately presented itself. Since the boy was born in Yonkers and had never resided outside the city, and because malaria is almost unheard of in this area,[7] it seemed logical to suspect the blood transfusions which the patient received at the other hospital.

From the Pediatric Service of the Yonkers Professional Hospital.

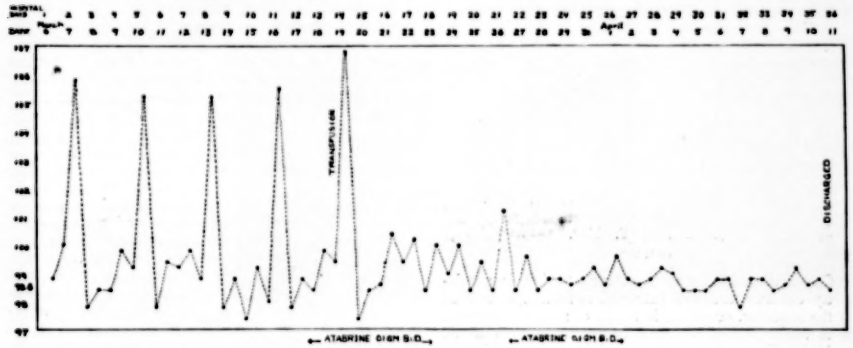
1. Wright, F. H.: J. Pediat. **12**: 327 (March) 1938.
2. McCulloch, Ernest: Canad. M. A. J. **37**: 26 (July) 1937.
3. Gardner, W. A., and Dexter, Lewis: Case of Quartan Malaria Following Transfusion and Treated with Sulfanilamide, J. A. M. A. **111**: 2473 (Dec. 31) 1938.
4. Zussman, B., and Silver, A.: M. Rec. **148**: 176 (Sept. 7) 1938.
5. Nabarro, David, and Edward, D. G. F.: Lancet **2**: 556 (Sept. 2) 1939.
6. Chamorro, T. A., and Molezzun, R.: Semana méd. **2**: 908 (Oct. 20) 1938.

7. Only 1 case was reported to the Yonkers Health Department during the past ten years, and 26 cases, during the same period from Westchester County.

Through the cooperation of that hospital it was possible to establish contact with the two donors and obtain samples of their blood for study. One was a man aged 29 who was born and had lived all his life in Yonkers. He gave no history of any infection. His blood was eleven days old when it had been given to the patient.

The other donor was a man aged 50 who was born in Italy and had lived there until 1905, when he migrated to the United States. He could not recall any illness there or any in his family that resembled a malarial infection. His family were farmers, apparently of good, healthy stock. He entered in the United States Army during the World War and was in France fourteen months. While there he contracted an ill defined febrile illness lasting two or three days but not severe enough to call it to the attention of the army physician. In 1921 he was operated on at Mount Sinai Hospital for "pus on the kidney" secondary to osteomyelitis of the distal phalanx of the left thumb, which had been draining for more than a year. He made an uneventful recovery from the operation, and since then his health has been excellent. When his blood was used for the patient it had been stored for two days.

Thick drop blood smears were made of both men's blood. They were first given a hypodermic injection of 5 minims (0.31 cc.) of a 1:1,000 solution of epinephrine, and fifteen minutes later the blood was drawn. Dr. Russell found the blood from the first (i. e., the American-born) donor normal; after a considerable length of time he discovered a few malarial parasites like those seen in the patient's blood in the blood of the donor who was born in Italy.



Progress of patient in hospital.

COMMENT

When it was found that the blood of one human being could be injected into the circulation of another, the physician's armamentarium in the fight against disease was tremendously augmented. Today the indications for the application of transfusion are legion. Its use is no longer restricted to those persons who are desperately ill, but, as far as the pediatrician is concerned, transfusion is frequently utilized prophylactically to prevent the development of serious complications.

No one can estimate the number of transfusions given all over the world every year, but one can imagine that it is great. The total count must be staggering when it is recalled that the first transfusion was given as far back as 1667 by Denys.[8]

Potential dangers of a blood transfusion are recognized. Besides malaria, one has read or heard of instances of syphilis, tuberculosis, smallpox and sepsis innocently acquired through the administration of some one's blood, but it must be admitted that the total number of infections is infinitesimally small when compared to the total number of transfusions. The fact that accidents have occurred and probably will recur in the future should constantly remind physicians of such hazards and stimulate them to bend their efforts to minimize these incidents. Another factor of utmost importance is that technical difficulties at present make these unfortunate occurrences almost unavoidable. Neither the hospital nor the physician can be blamed for this circumstance.

The preservation of blood for transfusion is a recent development in medical therapeutics. Many hospitals all over the world now have blood banks as part of their services. The manner in which the blood is collected and preserved is familiar to all, and numerous articles on the subject have been written.[9] Suffice it to state that every known precaution is observed to prevent such an accident as the one here described. Before a prospective donor is used he is asked many questions, including questions about his place of birth, occupation, residence in the tropics and illnesses such as malaria and syphilis.

The donor used for the patient under consideration was subjected to such scrutiny and apparently was found to be suitable. The only criticism that might be made about this man's blood being taken is that he was born in a country where malaria is known to be endemic and therefore should have been rejected on that basis alone, despite the negative history and blood analysis.

Certain procedures in the preservation of blood might be adopted to aid in minimizing the opportunities to spread infection from man to man. By employing only those persons who have been born in this country and have never lived in districts where malaria is prevalent, physicians would be taking a long step forward. Secondly, an examination of a thick drop preparation would appear to be essential. Finally, to be absolutely sure that malaria would not be transmitted the blood ought to be stored for at least eight days before being

8. Cited by Powers, G. F.: Blood Transfusion as a Therapeutic Procedure, in Brennemann, Joseph: Practice of Pediatrics, Hagerstown, Md., W. F. Prior Company, Inc., vol. 1 chap. 14, p. 1.

9. Fantus, Bernard: Therapy of Cook County Hospital: Blood Preservation, J. A. M. A. **109**: 128 (July 10) 1937; Blood Preservation Technic, ibid. **111**: 307 (July 23) 1938; Mod. Hosp. **50**: 57 (Jan.) 1938.

used. Ackermann and Filatov [10] and Antschelewitsch [11] have shown, by both human inoculations and in vitro experiments, that the plasmodia gradually degenerate and finally disappear from the blood the longer the blood is stored. The former investigators were unable to transmit malaria in 22 psychotic patients after known infected blood had been kept in the refrigerator for five days or longer. In his series Antschelewitsch was able to infect persons with malarial blood which had been preserved up to the eighth day. After that time every attempted transmission failed.

SUMMARY

1. A 7 year old white boy contracted quartan malaria through the administration of stored blood. The plasmodium was found also in the blood of the donor, who gave no history of malaria.

2. The incubation period was somewhere between thirty-three and forty-four days after the transfusion. Mühlens and Kirschbaum [12] and Joyeux [13] estimated the period of incubation for the parasite to be between twelve and fifty days.

3. The procedure which is outlined would help to avoid a repetition of the kind of accident described.

4. The foregoing case is the first of its kind to be reported.

27 Ludlow Street.

CALCIFICATION OF THE SUPRASPINATUS TENDON

A NEW TREATMENT

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AND
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Calcification in the supraspinatus tendon is a relatively common cause of pain and limitation of motion of the shoulder, occurring in adults of all ages, although it is most frequently found between the ages of 30 and 45. No cases have been reported among children. This condition is often erroneously diagnosed as bursitis, periarticular arthritis, brachial neuritis, paralysis of the radial nerve or rheumatism.

Our purpose in this paper is to discuss briefly the etiology, symptoms and physical findings and to present a method of medical management which has proved successful in a number of instances.

ETIOLOGY

The cause of calcification in the supraspinatus tendon is unknown. The tendon is so situated that it is subject to frequent mild trauma by being pinched between the head of the humerus and the acromion. Most recent writers have been of the opinion that injury to the tendon is a definite factor in the production of the calcareous deposits, yet in few cases is there a history of a definite single trauma. There is little evidence to show that calcification occurs more frequently in those people whose occupation requires the use of the arm held in slight abduction, such as piano players, typists, scrub women, painters, tailors and professional baseball players. Among them the supraspinatus tendon must receive frequent mild trauma.

That some other factor than trauma is implicated is evidenced by the fact that the deposit of calcareous material occurs only in adults; that it occasionally is encountered in first one shoulder and then the other; that in some persons the deposit undergoes absorption, while in others it persists; that although it is a common affliction, it never develops in many persons using their arms in the same way and subjected to the same influences, and that it occurs in athletic as well as among sedentary and asthenic persons and in females as well as in males.

No definite evidence of the relation of foci of infection to the appearance of calcified deposits in the supraspinatus tendon or between foci of infection and the exacerbations of pain from the deposits has been advanced. Cultures from the deposits and the surrounding tissues have been reported negative for pathogenic organisms. On the other hand, the pathologic picture is that of chronic inflammation. The calcareous material is embedded in masses of inflammatory cells, chiefly lymphocytes and plasma cells, among which may be found a few giant cells. Fibrous tissue in various stages of development and containing acutely inflamed patches usually surrounds the calcareous material. Foci of infection may be related to these deposits. A part that is subjected to mild repeated traumas or to direct violence is more susceptible to the action of toxins or other products of the growth of bacteria than one that is not. This was shown by Burrows [1] and might explain why these deposits develop and why acute exacerbations occur in some persons and not in others, although the two groups may have had the same predisposing factors. In 1 of our patients there was an increase of pain after an abscessed tooth was removed. In others, however, apparently complete recovery has occurred in spite of definite foci of infection remaining untreated. We advised removal of the foci of infection in all cases, but as the patients improved they did not care to have it done. We are interested in following these patients to see if the deposits recur or if the patients have acute exacerbations of pain.

Metabolic disturbances have been suggested as possible causative factors, but there is no clinical or laboratory evidence that such is the case. There seems to be no connection between this condition and gout.

SYMPTOMS AND PHYSICAL FINDINGS

Apparently the deposit of lime salts occurs quietly and precedes by a considerable interval the onset of clinical symptoms. The onset may be either gradual or acute. In either case most patients complain of pain in the region of the apex of the shoulder joint occasionally radiating down the anterior aspect of the arm or to the side of the neck. Movement may be little restricted in cases of chronic calcification, but when the condition is acute there is much muscular spasm and the arm may be held rigidly to the side. In cases of less acute calcification, there is usually a varying degree of limitation of abduction and external and internal rotation. Many patients complain of tenderness over the shoulder and state that they are unable to lie on the diseased part; at times even the pressure

10. Ackermann, V. V., and Filatov, A. N.: J. Trop. Med. **37**: 49 (Feb. 15) 1934.
11. Antschelewitsch, W. D.: Folia hæmat. **57**: 406, 1937.
12. Mühlens, P., and Kirschbaum, W.: Parasitologische und klinische Beobachtungen bei künstlichen Malaria- und Recurrensübertragungen, Ztschr. f. Hyg. u. Infektionskr. **94**: 1, 1921, cited by Wright.[1]
13. Joyeux, Charles: Précis de médecine coloniale, Paris, Masson & Cie, 1927; cited by Wright.[1]

From the Department of Medicine, University of Chicago.

1. Burrows, Harold: Some Factors in the Localisation of Disease in the Body, Baltimore, William Wood & Company, 1932.

of a coat is uncomfortable. Stiffness is not an uncommon complaint.

The contour of the shoulder joint usually shows little change, although there is occasionally slight atrophy of the muscles. In the cases of more severe calcification fulness at the apex of the shoulder may be observed together with redness, tenderness and induration. In the uncomplicated case, when the calcification of the tendon alone exists, tenderness is well limited to a point just below the acromial process. Fairly large deposits may occur in some persons without appreciable symptoms and are occasionally accidentally discovered.

On roentgen examination the calcareous deposits cast a shadow of varying density. The shadow may be thin and hazy or dense as bone. Shadows of the two extremes may exist in roentgenograms of the same patient. The deposits may be single or multiple and may be unilateral or bilateral. They vary in size from a few millimeters to several centimeters in diameter. They may escape detection when the roentgenogram is made from only one angle if the shadow of the deposit is superimposed on the shadow of the humerus or of the acromion. Especial emphasis should be placed on the proper roentgenologic technic because the failure to make a diagnosis has often resulted from failure to place the tube at a proper angle. The technic used by the roentgenologic department of the University of Chicago Clinics is as follows: The patient is supine with back to film; the arm is in neutral position with forearm across the abdomen —palm down. The tube is centered on the acromioclavicular joint; 50 to 60 kilovolts is used for a person of average weight, and the tube is at 36 inch distance. A Bucky-Potter grid and high detail screens are used.

Fig. 1 (case 1).—Calcification in supraspinatus tendon of right shoulder: *A*, measuring 3 by 1 cm.; *B*, decrease in size one month after institution of treatment; *C*, almost complete disappearance six weeks after institution of treatment.

Fever is not usually present in this condition, but during the acute stage there may be moderate leukocytosis and a slight increase in the sedimentation rate of the blood.

TREATMENT

The management of patients with calcification of the supraspinatus tendon is largely dependent on whether the condition is acute or chronic. Obviously when the calcified material is present without causing symptoms there is little need for treatment.

Until recent years the best treatment in the acute stage was considered by many, especially surgeons, to be surgical excision of the calcified material. That this procedure is questionable in the majority of patients is evidenced by the excellent results obtained by medical management.

The treatment that we have used with good results during the past few years consists of (1) relatively large doses of ammonium chloride, (2) rest of the diseased part, (3) physical therapy and (4) elimination of foci of infection.

In reviewing the literature we have found no reference to the use of ammonium chloride or other means of lowering the hydrogen ion concentration of the blood and lymph in the treatment of the condition. On this management there is a rapid disappearance of pain in the acute stage, and, when the deposit is not too dense, the ammonium chloride appears to cause an absorption of the calcified material. It is given in doses of 1 Gm. or more four times a day. If given after meals it seldom causes gastric discomfort. If it should, enteric coated tablets are available. The purpose of the ammonium chloride is to produce mild acidosis which tends to absorb deposits and acts somewhat similarly to the process of deleading in chronic lead poisoning. We realize that occasionally the deposits will disappear spontaneously, but we believe the ammonium chloride exerts a favorable influence in the process of absorption.

Rest of the diseased part is important. Patients should be instructed to refrain, as far as possible, from performing those movements of the shoulder which their own personal experience has shown to cause pain. Each time pain is inflicted the underlying lesion is subjected to further trauma with consequent aggravation and prolongation of symptoms. Some physicians endeavor to obtain rest of the diseased part by holding the arm at a 120 degree angle on various forms of splints or plaster casts or by tying the wrist to the head of the bed. Such positions are rather uncomfortable, and patients are prone to consider such treatment worse than the disease. Proper rest of the diseased part can usually be obtained during the day by a properly applied sling, and at night a 40 to 60 degree angle of abduction can be obtained by resting the arm and forearm on a pillow which is placed with one end on the mattress and the other end over the chest and the abdomen of the patient.

Physical therapy in its various forms is helpful but if used injudiciously may cause an aggravation of symptoms. Diathermy is probably the best form of physical therapy in this condition, but if it is not available or expense prohibits its use an infra-red lamp for thirty minutes two or three times a day is a good substitute. Gentle massage combats the tendency to atrophy and may aid in the relief of pain, but it should not be employed directly over the tender area.

Foci of infection are usually apical dental infections, pyorrhea alveolaris, infected tonsils, infected nasal sinuses, chronic nasopharyngitis, cervicitis or prostatitis. Careful search for these foci of infection should be made and proper treatment given.

The results obtained by the method of treatment outlined are well illustrated by the following consecutive

reports of several patients who have been treated during the past few months. The majority of these patients had been treated by the usual methods before coming to the University Clinics.

REPORT OF CASES

CASE 1.—V. W., a 44 year old housewife, came to the arthritis clinic March 5, 1940, complaining of severe pain in

Fig. 2 (case 2).—Calcification in supraspinatus tendon of right shoulder: *A*, measuring 2 by 0.8 cm.; *B*, decrease in size to 4 by 3 mm. six months later.

the right shoulder and upper arm with inability to move the arm at the shoulder for the preceding four days. She had noticed slight pain in the right shoulder at intervals for four or five months, especially after ironing. There was no history of injury, but she had done a good deal of ironing for several years. For the past four days before coming to the clinic, the pain was so severe she could not sleep and she could not lie on the right side.

Examination of the shoulder showed an area of localized tenderness just below the acromion. None of the movements at the shoulder could be performed on account of intense pain. The soft tissues over the area of tenderness were swollen, indurated and slightly reddened.

The urine was normal; the Wassermann and Kahn tests gave negative results. Examination of the blood showed hemoglobin, 84 per cent; white blood cells, 11,800, and sedimentation rate, 3 mm. per hour. Serum calcium was 8.8 mg. per hundred cubic centimeters; phosphorus, 2.9 mg. per hundred cubic centimeters; carbon dioxide, 29.7 millimols per liter; hydrogen ion concentration of serum, 7.4, and uric acid, 2.4 mg. per hundred cubic centimeters. A roentgenogram of the shoulder showed a spectacular degree of calcification in the right supraspinatus tendon, the deposit measuring 3 by 1 cm.

The arm was immobilized; the patient was given 1 Gm. of ammonium chloride four times a day and advised to have inductotherm treatments. Because of financial conditions she could not get the inductotherm treatments, and she was advised to use an infra-red lamp for thirty minutes three times daily.

She was seen again on March 12, 1940, a week after the first visit, and reported a noticeable decrease in the severity of the pain. She was able to sleep and could abduct the arm to an angle of 60 degrees.

A week later she was again seen and had had no pain in the shoulder. She was able to abduct the arm to an angle of 90 degrees.

Roentgenograms of the shoulder taken one month after treatment showed considerable absorption of the deposit.

Roentgenograms taken two months after treatment was begun showed almost complete disappearance of the deposit.

CASE 2.—The patient, a 39 year old housewife, was first seen in the arthritis clinic on Sept. 15, 1939, and complained of pain in the right shoulder at intervals for four or five years. During the past year the pain had been present daily. She had also noticed tenderness over the shoulder and an inability to raise the hand to the head. She was awakened frequently on account of the pain, especially when she turned on the right shoulder. There was no history of injury.

Examination revealed a point of tenderness just below the acromion of the right shoulder, but there was no swelling or redness. Abduction of the shoulder was limited to 110 degrees, and there was a moderate degree of limitation of internal and external rotation.

The urine was normal; Wassermann and Kahn tests gave negative results. The blood showed white cells, 10,900; hemoglobin, 83 per cent; sedimentation rate of erythrocytes, 16 mm. per hour; blood uric acid, 2.1 mg. per hundred cubic centimeters; hydrogen ion concentration of serum, 7.43; carbon dioxide serum, 28.2 millimols per liter; serum phosphorus, 3.1 mg. per hundred cubic centimeters; serum calcium, 8.9 mg. per hundred cubic centimeters, and basal metabolic rate, —13.

Dental roentgenograms showed one tooth with a large periapical lesion.

Roentgenograms of the cervical portion of the spine showed normal conditions.

Roentgenograms of the right shoulder showed a calcification in the supraspinatus tendon measuring 2 by 0.8 cm.

The patient was advised to immobilize the right arm in a sling, to use an infra-red lamp on the shoulder for thirty minutes three times a day and to take ammonium chloride, 1 Gm. four times a day. She was advised to have the tooth with the periapical lesion removed. This was done, and for a few days afterward the pain in the right shoulder increased. One month later the pain had entirely disappeared except on extreme internal rotation. Six months later when the patient was seen again she had no pain on motion of the arm or when at rest, and the motion at the shoulder was free in all directions. A roentgenogram taken at this time showed that the deposit had decreased in size from 2 by 0.8 cm. to 4 by 3 mm., and only a trace of the calcium remained.

CASE 3.—A 43 year old Jewish woman came to the arthritis clinic on Aug. 14, 1939, complaining of severe pain in the left shoulder of two weeks' duration. She had noticed her inability to comb her hair or put on her dress. She also had noticed transient pain in the right shoulder. There was no history of injury.

Examination showed a point of tenderness just below the acromion and tenderness of the muscles of the left arm and shoulder. All movements of the shoulder were limited. There was no tenderness of the right shoulder, and motion was free and unimpeded.

Fig. 3 (case 3).—Calcification in supraspinatus tendon of left shoulder: *A*, measuring 2 by 0.4 cm.; *B*, complete disappearance four months after institution of treatment.

The urine was normal; Wassermann and Kahn tests gave negative results. The blood showed hemoglobin, 85 per cent, and white blood cells, 9,900.

Roentgenograms of the shoulders were not obtained at the first visit. The patient was advised to put the arm in a sling and to use an infra-red lamp for thirty minutes twice a day and was given sodium salicylate, 0.6 Gm. four times a day. She returned two weeks later but had had little relief.

Roentgenograms at this time showed calcification of both supraspinatus tendons, more extensive on the right. The deposit

in the left supraspinatus tendon, where she had the acute symptoms, measured 2 by 0.4 cm.; that in the right, which was symptomless, measured 1 by 1 cm.

Dental roentgenograms showed no abnormalities.

There was a tonsillar tag in the right tonsillar fossa from which pus was expressed.

The patient was given 1 Gm. of ammonium chloride four times a day and inductotherm treatments twice weekly for six

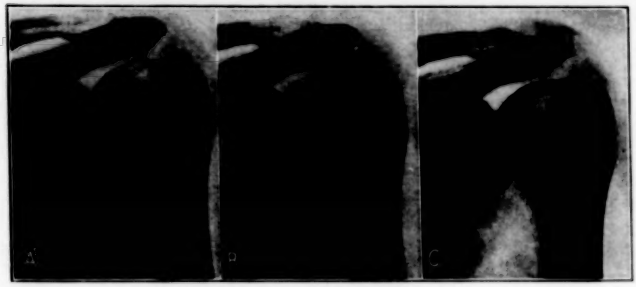

Fig. 4 (case 4).—Calcification in supraspinatus tendon of left shoulder: *A*, measuring 10 by 5 mm.; *B*, no change in size of calcification three months after institution of treatment but complete relief of symptoms; *C*, decrease in size to 7 by 1 mm. Dose of ammonium chloride increased from 4 Gm. to 6 Gm. a day one month previously.

treatments. This was supplemented by the infra-red lamp at home for thirty minutes twice a day. Relief from the pain occurred rapidly. She was last seen on Jan. 15, 1940, four months after treatment was begun. She had had no pain for three months; motion at the shoulder was free, and roentgenograms of the shoulders showed complete disappearance of the calcified deposit in the left supraspinatus tendon; the deposit in the right supraspinatus tendon, which was symptomless, showed no apparent change.

CASE 4.—A housewife aged 35 came to the University clinics on Nov. 23, 1939, complaining of pain and limitation of motion of the left shoulder at intervals for five years. She experienced pain only with certain motions, notably in raising the arm above the shoulder level and in reaching backward as in putting on a coat. There was no history of injury.

Examination showed a slight atrophy of the muscles about the left shoulder. Grating was present on motion of the shoulder. Abduction and internal and external rotation were moderately limited. There was a point of localized tenderness on deep pressure just below the acromion.

The Wassermann and Kahn tests gave negative results; the urine was normal. The blood showed hemoglobin, 84 per cent; red blood cells, 4,310,000; blood uric acid, 2.5 mg. per hundred cubic centimeters, and sedimentation rate of erythrocytes, 2 mm. per hour.

A roentgenogram of the left shoulder showed a calcification of the supraspinatus tendon 10 by 5 mm. A roentgenogram of the right shoulder showed it to be normal.

The patient was advised to use heat and massage on the shoulder and to immobilize the arm in a sling. She was started on ammonium chloride, 1 Gm. four times a day, on Dec. 6, 1939. On December 27 she stated that she had had no pain except on extreme motion.

On Jan. 24, 1940, she had no pain at rest or motion of the shoulder. Abduction was slightly limited, but internal and external rotation could be performed with ease.

On March 20, 1940, three months after institution of treatment, all movements at the shoulder were free and painless.

Roentgenograms of the shoulder on March 20, 1940, showed no apparent change in the appearance of the calcification.

On May 13, 1940, the dose of ammonium chloride was increased from 4 Gm. to 6 Gm. a day. Roentgenograms of the shoulder taken one month later showed a decrease in size of the calcification from 10 by 5 mm. to 7 by 1 mm.

CASE 5.—The wife of a physician, aged 45, was admitted to Billings Hospital on Dec. 11, 1939, complaining of severe pain in the right shoulder. She had noted slight pain in the right shoulder for six months prior to the present acute exacerbation. This mild discomfort had persisted until two weeks before admission, when it suddenly became intense and unremitting and kept her awake at night. She had been unable to move her arm from her side because of the extreme pain on slight motion. There was no history of injury.

Examination showed tenderness about the right shoulder, especially just below the acromial process. No swelling or redness was present. No motion at the shoulder could be performed on account of the extreme pain.

The Wassermann and Kahn tests gave negative results; the urine was normal; the blood showed white blood cells, 9,800; hemoglobin, 84 per cent; red blood cells, 4,650,000; blood uric acid, 0.7 mg. per hundred cubic centimeters; cholesterol, 222 mg. per hundred cubic centimeters, and serum calcium, 10 mg. per hundred cubic centimeters.

A roentgenogram of the right shoulder showed a large calcification in the right supraspinatus tendon, measuring 2.5 by 1 cm.

Dental roentgenograms showed numerous pulpless teeth with incomplete root canal therapy, one of which had an apical granuloma.

The patient was placed on a ketogenic diet and given syrup of ammonium mandelate, 10 cc. four times a day, and ammonium chloride, 1 Gm. four times a day. This was continued from Dec. 13, 1939, to Dec. 30, 1939, at which time the dose of the drugs was reduced by one half and the regular diet resumed.

Blood carbon dioxide was 17.1 millimols per liter December 15; 18.1 millimols per liter on December 16, and 20.0 millimols per liter on December 20. The hydrogen ion concentration of the serum on the same days was 7.39, 7.33 and 7.36.

On this regimen the urine showed acetone, a trace to 1 plus.

Fig. 5 (case 5).—Calcification in supraspinatus tendon of right shoulder: *A*, measuring 2.5 by 1 cm.; *B*, complete disappearance four months after institution of treatment.

The patient was given daily inductotherm treatments during this period.

She obtained rapid relief from the pain. On December 15 the pain was gone at rest and on December 18 motion was only slightly limited by the pain. She had slight disability for about three weeks more.

A roentgenogram taken on April 9, four months after the onset of pain, showed complete disappearance of the deposit. There was no limitation or pain on motion.

SPONTANEOUS LUXATION OF THE EYEBALL

REPORT OF AN INSTANCE IN A BRACHYCEPHALIC PATIENT

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There is little to be found in ordinary textbooks on ophthalmology on the subject of spontaneous luxation of the eyeball. Some confusion has resulted because of the use of the synonymous terms "dislocation" and "luxation." The word "avulsion," while in no sense a synonym of these two words, when applied to the eyeball does describe a condition which may result from the same type of injury that can cause luxation. Berens [1] mentioned luxation as being due to injury. Fuchs [2] and others mentioned instances of luxation of the eye which occurs traumatically in certain barbarous tribes in which gouging of the eyes in fights and brawls is practiced. A cow horn injury has been known to luxate a human eyeball, the horn acting as a lever and the orbital margin as a fulcrum. One old report (DeWecker, cited by Parsons [3]) was of a pugilist who snatched his eye off and threw it to the floor after his opponent had luxated it by a blow. Kimball [4] described the case of a white man aged 30 with dementia praecox. The patient had attended a university for two years. He began the process by pushing his index finger into the orbit beside his left eye. Six months later he was able to extrude the eye and lay it alongside his nose. The eye had complete optic atrophy.

Fig. 1.—Idiopathic dislocation of the eyeball (after Greig).

While the luxations in the cases just mentioned were not spontaneous, they illustrate how injury may produce luxation without causing avulsion. Ball [5] and Wood [6] described luxation and dislocation, and the latter repeated Barck's classification of displacement of the eyeball:

1. Luxation refers to protrusion of the eye between the eyelids, with spastic closure of lids behind the eye. It occurs spontaneously in the presence of exophthalmos. Most cases are due to shallow orbits.

2. Dislocation refers to displacement of the eye into the nasal sinuses or nasal cavity and is due to trauma.

3. Avulsion refers to partial or complete severance of extraocular eye muscles and the optic nerve, or both, from the body.

Parsons [3] mentioned the same classification, quoting Birch-Hirschfeld, and described luxation as being due to parturition, injury or accident, although he went on to say that it may occur spontaneously or be brought about at will by some persons with lax fascia.

It is my purpose here to discuss forward displacement of the eyeball (luxation) which occurs spontaneously. A pursuit of the literature on this subject has revealed a number of unique clinical experiences. Graefe and Saemisch [7] described spontaneous luxation as occurring in exophthalmic goiter when exophthalmos is extreme. Tucker [8] reported 2 instances in adults: 1 was due to exophthalmic goiter, and both eyes of the patient luxated by gentle pressure on the lower lids; the other was due to cerebral syphilis, probably gumma. The associated exophthalmos improved under treatment in each case. Oertel [9] reported the case of a Negro woman aged 25 whose eye luxated when one of his students was retracting her lids with his fingers. The eyeball had come out on several occasions by itself, especially when she stooped over. Vision was 20/20 in each eye. Both eyes were prominent but there were no signs of goiter. Two months later she died and a small tumor of the cerebellum was found at autopsy. Oertel cited Galloway,[10] who described a luxation which occurred as he was removing a foreign body from the cornea and retracting the lids with his fingers, and cited also a case of Levin's [11]—that of an obese man aged 53 with bilateral exophthalmos and eyes which luxated spontaneously yet with no other evidence of exophthalmic goiter. Others in this patient's family had exophthalmos. Mertens [12] was examining a Negro man aged 38, and as he retracted the lids with his

Fig. 2.—Appearance of patient with spontaneous luxation of eyeball.

From the wards of the Children's Hospital.
Dr. Ralph De Graff prepared the photographs and conducted the roentgen examination.

1. Berens, Conrad: The Eye and Its Diseases, Philadelphia, W. B. Saunders Company, 1936.
2. Fuchs, Ernst: Text-Book of Ophthalmology, translated by Alexander Duane, ed. 8, Philadelphia, J. B. Lippincott Company, 1924.
3. Parsons, J. H.: Pathology of the Eye, London, Oxford University Press, 1908, vol. 4, pt. 2, p. 1179.
4. Kimball, A. H.: Voluntary Displacement of the Eye, J. A. M. A. **62**: 1085 (April 4) 1914.
5. Ball, J.: Modern Ophthalmology, Philadelphia, F. A. Davis & Company, 1926, p. 1106.
6. Wood, C. A.: American Encyclopedia and Dictionary of Ophthalmology, Chicago, Cleveland Press, 1915, vol. 6, p. 4037.
7. Graefe, Alfred, and Saemisch, Theodor: Handbuch der gesamten Augenheilkunde, Leipzig, Wilhelm Engelmann, 1907, vol. 9, pt. 2, p. 39.
8. Tucker, B. R.: Two Cases of Dislocation of Eyeball Through the Palpebral Fissure, J. Nerv. & Ment. Dis. **34**: 391 (June) 1907.
9. Oertel, T. E.: Spontaneous Luxation of the Eyeball, Am. J. Ophth. **3**: 814 (Nov.) 1920.
10. Galloway, A. R.: Luxation of the Eyeball, Ophthalmoscope **8**: 262 (April) 1910.
11. Levin, H.: Fall von spontaner Luxation des Bulbus, Berl. klin. Wchnschr. **42**: 1105, 1905.
12. Mertens, P. S.: Subluxation of the Eyeball, Am. J. Ophth. **5**: 290 (April) 1922.

fingers either eye would pop out of its orbit. Vision was 20/20 in each eye, and the fundi were normal, with no history of spontaneous luxation.

Another group of cases, which seems related to the group just mentioned yet presents in itself probably a

Fig. 3.—Prominence of eyes and alternating divergence are apparent.

distinct entity, is composed of instances in which the eye can be voluntarily luxated. Lyle and McGavic [13] reported a case of a Negro man who had made his living by exhibiting his ability to luxate his right eye. He was unable to luxate his left eye. Autopsy, following death from pneumonia, revealed in the left orbit only normal eye muscles, but in the right there were a bifurcated superior oblique muscle and two inferior oblique muscles. The orbit was 44 mm. deep. The authors concluded that the protractor action of the four oblique muscles in one orbit enabled him to pull his eye forward between his lids. Almeida [14] reported the cases of two Negroes with spontaneous luxation of the eyes. One of them had a goiter. Almeida expressed the belief that spontaneous proptosis occurred exclusively in the Negro race and that shallow orbits and relaxed ligaments were necessary adjuncts. He gave Willemer [15] credit for describing the first case of spontaneous luxation and also mentioned Pereira Gomes' [16] case of a Negro girl. DePontal (cited by Ball [5]) saw a young man who could luxate his eye by blowing his nose violently. Smith [17] described the case of a Negro boy aged 11 years who could voluntarily propulse both eyes. Vision was 20/30 in each eye. He had normal fields and fundi but appeared subnormal mentally. At first he had had to press his eyes out with his fingers but had with practice learned to do it without their help. Ferrer [18] wrote of a half-breed man aged 20 who at the age of 5 or 6 years began voluntarily to displace both eyeballs. The fields were normal. Vision was 20/40 in the right eye and 20/30 in the left. The orbits were shallow. He had a high palate and was mentally defective. Ferrer expressed the belief that the patient's unusual ability to contract his protractor muscles made him able to luxate his eyes.

Then there is the group in which luxation occurs spontaneously because of the shallow orbits of a deformed skull. Power [19] in 1893 reported the case of a child with both eyes luxated. He wired the lids together to prevent luxation. Greig's [20] patient was an 11 month old emaciated girl (fig. 1) whose prominent eyes would bulge outward and extrude when she cried. Her cranial sutures were very prominent, but Greig stated that the orbits were not shallow. He suggested abnormal Müller's muscles as the cause of the luxation. Donaldson's [21] patient was a 2½ year old boy who had had prominent eyes since birth. His head was deformed and dysostosis was present. One eye had been luxated eleven times, but the tendency became less as the child grew older. Fletcher,[22] in reporting a series of cases of oxycephaly, mentioned Hutchinson's patient, a girl aged 12 years, with oxycephaly whose one eye was "dislocated" on one occasion. Franceschetti's [23] patient with "dysostose cranio-faciale héréditaire" had luxation of the eyeballs.

The following case of luxation of the eyeball due to brachycephaly is, I believe, the first of its kind recorded

Fig. 4.—Lateral view of skull.

with complete roentgenographic studies and photographs.

13. Lyle, D. J., and McGavic, J. S.: The Cause of Voluntary Forward Luxation of the Eyeball, Am. J. Ophth. **19**: 316 (April) 1936.

14. Almeida, A.: Willkürlich hervorgerufene Luxation des Augapfels, Klin. Monatsbl. f. Augenh. **88**: 223 (Feb.) 1932.

15. Willemer, H.: Cor. Bl. d. allg. mecklenb. Aerztever., 1892, no. 144, p. 570; cited by Almeida.[14]

16. Pereira Gomes: Ann. paulist. de med. e cir., August 1919; cited by Almeida.[14]

17. Smith, J.: Voluntary Propulsion of Both Eyeballs, J. A. M. A. **98**: 398 (Jan. 30) 1932.

18. Ferrer, Horacio: Voluntary Propulsion of Both Eyeballs, Am. J. Ophth. **11**: 883 (Nov.) 1928.

19. Power, H.: A Case of Microcephalus with Proptosis, Tr. Ophth. Soc. U. Kingdom **23**: 264, 1903.

20. Greig, D. M.: Idiopathic Dislocation of Eyeball, Edinburgh M. J. **18**: 129 (Feb.) 1917.

21. Donaldson, E.: A Case of Deformity of the Head and Proptosis, Tr. Ophth. Soc. U. Kingdom **23**: 264, 1903.

22. Fletcher, H. M.: On Oxycephaly, Quart. J. Med. **4**: 386 (April) 1911.

23. Franceschetti, A.: Dysostose cranio-faciale héréditaire, in Baillhart, P.; Coutela, Charles; Redslob, E., and Velter, E.: Traité d'ophthalmologie, Paris, Masson & Cie., 1939, vol. 6, p. 428.

REPORT OF CASE

In February 1940 I was called to the dispensary of the Children's Hospital to see a 2½ year old girl with an "extruded" eye (fig. 2). She had never walked. She had a cold and a fever. While she was sitting on the floor she looked up and her right eye "popped out." Whether she was crying at the time or coughing could not be determined. During her subsequent stay in the hospital she cried, coughed and sneezed a great deal. When I first saw her the eye had been luxated one-half hour. Pushing it back seemed impossible, because the lids were spastically closed behind it. A hook was slipped under the upper tarsus and as the upper lid was brought forward the eye readily fell back into the socket. The lids were taped shut for a few days. Her cold improved, and during her ten day stay in the hospital her eye did not luxate again. Up to the present writing (June 1940) the child has remained well and no further luxations have occurred.

Physical examination revealed a deformed skull, a large open anterior fontanel, poorly formed teeth and a high arched palate. Her eyes were prominent (fig. 3), yet the lids covered them easily. The lids looked large. The pupils seemed normal. There was an alternating divergence, as seen in figure 3. The general musculature was weak. A Wassermann test was negative. The eyegrounds were normal. The pupils dilated readily with homatropine. There was no optic atrophy, no papilledema and no retinal hemorrhages. A differential blood cell count was negative.

Roentgen examination of the skull in anteroposterior and lateral views (fig. 4) showed a definite foreshortening of the skull in the anterioposterior dimension, with flattening in the occipital region. The orbital cavities were shallow. There was synostosis of the sutures and evidence of intracranial pressure, as seen by convolution atrophy in the occipital region and upward bulging of the bone and pressure atrophy in the region of the anterior fontanel. The diagnosis was brachycephaly.

Rubin [24] gave a complete survey of oxycephaly. It is due to premature synostosis of the bones of the skull. Various deformities due to this condition are (1) scaphocephaly—narrow skull with bulging forehead and occiput; (2) dolichocephaly—long, narrow skull; (3) brachycephaly—short, wide skull, and (4) oxycephaly—high-domed or tower skull. In cleidal dysostosis, the skull is usually of the brachycephalic type. The word "oxycephaly" is predominantly used throughout the text, the other prefixes denoting variations in shape of the skull due to the underlying premature synostosis. The commoner eye changes are listed as optic atrophy, amaurosis, exophthalmos, divergent strabismus and nystagmus. All observers cited found these defects in a large percentage of their cases. Various observers have estimated the incidence of oxycephaly to be from 1 per cent to 12.4 per cent of the population. Many criminals and persons with mental disease have oxycephaly. "Exophthalmos is due to the shallow orbits, and may be unequal. Dislocation of eyes is reported."

From the literature one must conclude that spontaneous luxation of the eyeball, though rare, has been described a number of times, and if one studies reported cases a varied etiology is at once apparent. The related terms of dislocation and avulsion properly refer to trauma. Luxation of the eye should be further qualified as:

1. Spontaneous—arising from (*a*) oxycephaly, brachycephaly and related conditions due to premature synostosis; (*b*) prominent eyes—usually in Negroes or (*c*) exophthalmic goiter (in which disease luxation occurs very rarely).

2. Voluntary—usually found in mentally subnormal Negroes. Probably luxation is due to protractor action of oblique muscles. In some cases it begins as a self-induced anomaly.

3. Self induced—found in persons with mental disease. Later may become voluntary or at least very easily accomplished.

4. Traumatic—eye is luxated but not avulsed by trauma.

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24. Rubin, M. I.: Premature Synostosis and Associated Phenomena, in Brennemann, Joseph: Practice of Pediatrics, Hagerstown, Md., W. F. Prior Company, Inc., 1940, vol. 4, chap. 25.

RENAL INSUFFICIENCY FOLLOWING TRANSFUSION

REPORT OF THIRTEEN CASES

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During the past few years we have had the opportunity to observe 5 instances of renal failure after transfusion. Indeed, one of us in the course of his private practice within a few months was called to see 3 patients with this condition. In none of these cases had the attending physician thought of the transfusion as a causative factor in his patient's illness. It seems probable, therefore, that it occurs more commonly than is generally realized and that frequently the diagnosis is not made. Those patients who are treated with transfusions of blood are often suffering from some severe illness which in itself may cause renal failure, so the transfusion is too often not considered the cause of the difficulty. Since the methods of grouping, cross matching and transfusing blood have been perfected, transfusion has become so common that respect for its hazards has waned. There is no branch of medical practice in which it is now not a common mode of therapy. So we think it worth while again to call the attention of the profession to one of the serious reactions that may follow transfusion.

Denys [1] described hemolytic reactions with "sooty urine" when he transfused the blood of a lamb into man in 1667. The work of Landsteiner,[2] Jansky [3] and Moss [4] on the isoagglutinins and the isohemolysins of human blood has made of transfusion a reasonably safe mode of therapy. But, in spite of careful blood grouping and cross matching, serious sequelae still develop. Bordley [5] in 1931 first brought clearly to the attention of American physicians the knowledge that renal failure sometimes followed transfusion. He said: "In not a single case is there complete and satisfying evidence to prove that the blood of the donor was compatible with that of the recipient." We agree with this statement. In general, his opinion has been confirmed, though there are several instances on record in which reexamination seemed to indicate an in vitro compatibility.[6]

1. Cited by Wiener, A. S.: Blood Groups and Blood Transfusion, Springfield, Ill., Charles C. Thomas, Publisher, 1935, p. 37.

2. Landsteiner, Karl: Ueber Agglutinationserscheinungen normalen menschlichen Blutes, Wien. klin. Wchnschr. **14**: 1132, 1901.

3. Jansky, J.: Haematologische Studien bei Psychotikern, Klin. Sborn. **8**: 85, 1907.

4. Moss, W. L.: Studies on Isoagglutinins and Isohemolysins, Bull. Johns Hopkins Hosp. **21**: 63, 1910.

5. Bordley, James, III: Reactions Following Transfusion of Blood, with Urinary Suppression and Uremia, Arch. Int. Med. **47**: 288 (Feb.) 1931.

6. McCandless, H. G.: Hemolytic Transfusion Reaction with Oliguria, J. A. M. A. **105**: 952 (Sept. 21) 1935. Hansen Pruss, O. C., and Miller, B. N.: Uremia Following Blood Transfusion, South. M. J. **29**: 1033 (Oct.) 1936. DeGowin and Baldridge.[10]

In these hemolytic reactions the exact mechanism of the development of the renal lesions is not entirely clear. Ponfik [7] by the injection of heterogenous blood into dogs produced a clinical and pathologic condition similar to that found in man. Baker and Dodds [8] and DeGowin and his co-workers [9] have shown in animal experiments that if the urine is acid when hemoglobin is injected the acid hematin pigment will precipitate in the renal tubules, producing a blockage with a clinical picture of uremia similar to that seen in man. If the urine is alkaline, the hemoglobin will be passed in the urine without renal injury. Aside from blockage of the renal tubules a concomitant or independent tubular necrosis may occur. This is often serious enough to produce uremia and death. This has been demonstrated by DeGowin [10] both experimentally and in man.

At autopsy, the changes are predominantly in the kidneys, which are usually described as being enlarged and congested. Microscopically, the picture varies and the anatomic basis for the renal insufficiency is not always evident. The most constant observation is considerable interstitial edema, frequently associated with leukocytic infiltration. The most striking renal change, though it is not always of great degree or even present, is the occurrence of masses of brown pigment filling the tubules. This pigment is considered to be acid hematin derived from hemoglobin of the hemolyzed blood, which is said to impair renal function by obstructing the tubules. In addition, the tubular epithelial cells contain droplets of this pigment and show advanced degenerative changes often comparable to that seen in poisoning from mercury. The glomeruli are, as a rule, intact. The liver may show small areas of central focal necrosis. A general deposition of hemosiderin is frequent.

Bordley [5] originally advanced four hypotheses as to the mechanism of this renal failure. In view of subsequent work only two of these seem possible: first, the theory of tubular blockage by hemoglobin pigment and, second, the assumption that some portion of the free hemoglobin is nephrotoxic and capable of producing tubular degeneration, interstitial edema and leukocytic infiltration in the kidneys.

The most important and striking reaction to a blood transfusion is that due to an incompatibility of the bloods. Severe reactions have resulted from the transfusion of as small a quantity as 10 cc. of incompatible blood. In some cases, death has been almost instantaneous, probably from massive agglutination with embolism. Usually the reaction is more prolonged, and the symptoms fall into an immediate and a delayed group. The immediate reaction occurs during the transfusion. The patient may experience a severe chill, a rise in temperature, pains over the entire body but more particularly in the lumbar region, great restlessness and anxiety, a sensation of fulness in the head, precordial oppression, dyspnea, vomiting, flushing of the face and involuntary defecation. Collapse sometimes follows. In patients surviving the immediate reaction or in those who escape this a delayed reaction may ensue a few hours to a few days later. This is often ushered in by a chill and fever. Oliguria develops in all cases and frequently there is complete anuria. Hemoglobinuria and jaundice may appear. After a varying length of time, usually from three to twelve days, the patient either succumbs to uremia or recovers after diuresis.

During the last few years we have seen 5 instances of renal failure following transfusion. Through the cooperation of our colleagues, we have collected other cases occurring in Washington hospitals. We are reporting 13 instances of this entity.

REPORT OF CASES

CASE 1.—E. M., a white woman aged 63, admitted to Garfield Hospital Jan. 12, 1936 with a history of pernicious anemia since 1931, had been treated successfully with liver extract until she discontinued treatment a year before admission. The patient was well nourished, with pallor of the skin and mucous membranes and an icteric tinge to the scleras, papillary atrophy of the tongue, enlargement of the liver and spleen and hypertension, the blood pressure being 145 systolic and 75 diastolic. The hemoglobin content was 47 per cent. The erythrocyte count was 2,000,000 and the leukocyte count 7,000. The urine showed a trace of albumin. On January 18 she was given 500 cc. of citrated blood by transfusion. No typing was done, but cross matching was reported as satisfactory. A mild thermal reaction followed. On January 22 another transfusion of 500 cc. was given without typing but with satisfactory cross matching. Shortly after the transfusion there was a severe chill, marked clonus of the entire body, nausea and vomiting, a thready pulse and involuntary defecation. Four hours later she voided 360 cc. of dark, blood-tinged urine. The temperature rose to 105 F. and drowsiness developed. The following morning there were deep jaundice, irrationality, nausea and vomiting, a blood pressure of 80 systolic and 40 diastolic and rales at the bases of both lungs. One hundred and fifty cc. of dark brown urine was voided on this day. The leukocyte count was 30,800, with 75 per cent polymorphonuclears. The urine showed albumin (4 plus) and gave a 4 plus reaction to benzidine, with only a few white cells in the sediment. The second day after the transfusion generalized edema appeared, and in spite of an intake of 2,000 cc. of fluid only 90 cc. of urine was voided. Four days after the transfusion there were complete anuria, stupor and hiccup. The nonprotein nitrogen level of the blood

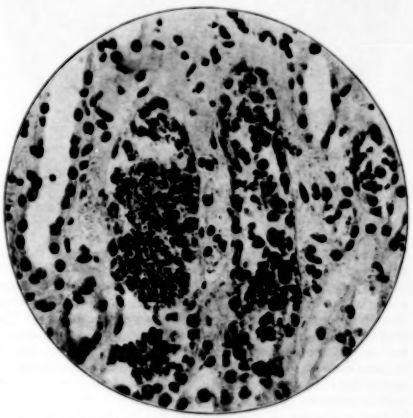

Fig. 1 (case 1).—Section of kidney showing the tubules filled with granular pigment. The tubular epithelium is swollen and in places desquamated. Interstitial edema is present. Reduced from a photomicrograph with a magnification of 377 diameters.

7. Ponfik: Experimentelle Beiträge zur Lehre von der Transfusion, Virchow's Arch. f. path. Anat. **62**: 273, 1875.

8. Baker, S. L., and Dodds, E. C.: Obstruction of the Renal Tubules During Excretion of Hemoglobin, Brit. J. Exper. Path. **6**: 247 (Oct.) 1925.

9. DeGowin, E. L.; Osterhagen, H. F., and Andersch, Marie: Renal Insufficiency from Blood Transfusion: I. Relation to Urinary Acidity, Arch. Int. Med. **59**: 432 (March) 1937.

10. DeGowin, E. L.; Warner, E. D., and Randall, W. L.: Renal Insufficiency from Blood Transfusion: II. Anatomic Changes in Man Compared with Those in Dogs with Experimental Hemoglobinuria, Arch. Int. Med. **61**: 609 (April) 1938.

was 160 mg. per hundred cubic centimeters, and the combining power of carbon dioxide was 33 per cent by volume. Death occurred five days after the transfusion. No typing or rematching was done.

At autopsy both lungs showed congestion and edema. The liver was slightly enlarged and dark brown. The spleen was

Fig. 2 (case 2).—Numerous tubules are filled with finely granular pigment and hyalinized material. There is interstitial edema and leukocytic infiltration. Reduced from a photomicrograph with a magnification of 87 diameters.

three times normal size, soft and of a mahogany color. The kidneys were enlarged, dark, deeply congested and edematous. The microscopic examination showed considerable interstitial edema with some infiltration of leukocytes. The tubules were greatly dilated and clogged with masses of dark pigment. The tubular epithelium was swollen and showed some desquamation, and deposits of granular pigment were present in the cells of the tubules. There was a definite increase of connective tissue in the glomerular tufts (fig. 1). Sections of the liver showed areas of necrosis about the central veins of the lobules.

CASE 2.—L. B., a white woman aged 28, admitted to Gallinger Hospital March 20, 1940 with bleeding from a threatened abortion, was given 80 grains (5.2 Gm.) of sulfanilamide because of suspected infection. Abortion occurred two days later, but the placenta was retained. Since the bleeding continued the placenta was removed manually and the uterus packed two days after the abortion. The patient was given 250 cc. of citrated blood from the blood bank. The blood of both recipient and donor was of type IV (Moss), and cross matching was satisfactory. On the patient's reacting from anesthesia, a chill occurred and there was a moderate rise of temperature. Nine hours after the transfusion 150 cc. of dark brown urine containing albumin (3 plus), dark brown casts and an occasional red cell and leukocyte was voided. The following day there was jaundice, frequent nausea and vomiting, and only 350 cc. of brown urine was passed, despite an intake of 3,700 cc. of fluid. Two days after the transfusion the nonprotein nitrogen level was 100 mg. and the creatinine 3 mg. per hundred cubic centimeters. The leukocyte count was 19,100, with 89 per cent polymorphonuclears. This day a large amount of alkali was given by mouth, and sodium bicarbonate was given intravenously, but only 75 cc. of brown urine was passed. During the following six days stupor, generalized edema, restlessness and retinal hemorrhages were noted. The blood pressure was 130 systolic and 70 diastolic. The daily total output of urine was 250, 385, 220, 250 and 190 cc., despite a daily intake of 3,000 cc. of fluid. Death occurred eight days after the transfusion. The recheck showed both the donor's and the recipient's blood to be type IV (Moss), and the cross matching was satisfactory. The autopsy revealed considerable congestion of both lungs and enlargement and congestion of the liver. Sections of the liver showed congestion only. The kidneys were swollen, enlarged and congested. The sections showed the glomeruli intact. The tubules were dilated, and there was flattening of the lining epithelium. Many of the tubules were filled with red cells in a hyalinized blood clot. All contained masses of finely granular pigment. There was considerable interstitial edema with some leukocytic infiltration (figs. 2 and 3).

CASE 3.—M. R., a white woman aged 50, admitted to the Emergency Hospital on Nov. 17, 1934 in a moderate degree of shock due to fractures of the femur and ribs, with considerable loss of blood, was given 500 cc. of citrated blood by transfusion. The patient and donor both had type IV (Moss) blood, and cross matching was reported satisfactory. There was no immediate reaction, but for three days after the transfusion there were nausea and vomiting without urinary suppression or any other abnormality aside from a trace of albumin and a few hyaline casts. Twelve days later, while under anesthesia for application of a cast, the patient was given 500 cc. of satisfactorily matched citrated blood. A chill occurred in thirty-five minutes, and the temperature rose to 103 F. Nausea, vomiting, jaundice and oliguria developed, associated with hemoglobinuria and hematuria. The urinary output per day was 150, 30, 13, 50, 70, 115 and 170 cc. On the fourth day the nonprotein nitrogen level was 56 mg. and chlorides 410 mg. per hundred cubic centimeters. By the seventh day the nonprotein nitrogen level was 75 mg. per hundred cubic centimeters. At this time Dr. R. E. Stetson, who had been called from New York, gave a direct transfusion of 500 cc. of blood after spending two hours in painstakingly grouping, regrouping and repeatedly cross matching the blood of the donor and the recipient with no results suggestive of any incompatibility. There was no immediate reaction, but thirty-five minutes later a chill and fever occurred, followed by jaundice, hemoglobinuria, hematuria, oliguria, nausea and vomiting. In spite of large amounts of physiologic solution of sodium chloride and hypertonic dextrose given parenterally, the total urinary output was on successive days 100, 225, 310, 414, 545, 715, 1,045, 1,140,

Fig. 3 (case 2).—Interstitial edema is present and the tubules are filled with finely granular pigment. Reduced from a photomicrograph with a magnification of 183 diameters.

1,295, 1,350, 1,455 and 1,240 cc. The abnormalities gradually decreased in the urine, but its specific gravity was fixed. On the fourth day after transfusion the leukocyte count was 30,000, with 98 per cent polymorphonuclears. The nonprotein nitrogen level was 90, the creatinine 3.6, chlorides 510 mg. and serum bilirubin 2.5 mg. per hundred cubic centimeters. The carbon dioxide combining power was 31 per cent by volume. General-

ized edema developed, and death with pulmonary edema occurred on the thirteenth day after the last transfusion.

The autopsy was limited to the abdomen. The only abnormalities were congestion of the liver, spleen and kidneys. Sections of the kidney showed areas of leukocytic infiltration throughout. The tubules were widely separated by delicate, pale, edematous, fibrous tissue. The tubules were dilated and the epithelium was granular and flattened. Their lumens only occasionally contained granular or fibrinous material or a globule of homogeneous hyalinized substance. The glomeruli were congested and for the most part well preserved. The blood vessels were decidedly sclerotic and in some cases completely obliterated by fibrous tissue (fig. 4).

Dr. Stetson [11] rechecked the blood of the donor and recipient carefully by both the macroscopic method and the Landsteiner technic. No agglutination or hemolysis occurred. However, when tube preparations of the donor's cells and the recipient's serum were incubated at 37.5 C. overnight there was marked agglutination and hemolysis. It was later ascertained that agglutination occurred regularly in thirty-five minutes when the preparations were incubated at 37.5 C. This is the exact time at which reactions occurred after the transfusions. The tests were repeated, various type IV cells being used with the patient's serum, and in the great majority this incompatibility was demonstrated.

CASE 4.—E. L. P., a white woman aged 28, had some edema of the ankles without hypertension or albuminuria during the last two months of her pregnancy. Her physical examination was negative. The urine showed no abnormality. The blood pressure was 130 systolic and 80 diastolic. On July 19, 1939 at Garfield Hospital she was delivered by high forceps of a large child after a hard labor. The placenta was retained. The following day, because of a temperature of 103 F., the placenta was removed manually under anesthesia. The third day after delivery the temperature was still high and sulfanilamide with sodium bicarbonate was given for two days and then stopped because of cyanosis. Three days after delivery the blood showed a hemoglobin content of 9.5 Gm., or 57 per cent, erythrocytes 3,000,000 and leukocytes 15,950. On this day the patient was given a transfusion of 500 cc. of citrated blood without a reaction. The blood of both donor and recipient were reported as type IV (Moss), and cross matching showed no agglutination. Three hours after the transfusion 90 cc. of "dark urine like argyrol" was obtained on catheterization, and thereafter all urine voided was dark brown. On examination the urine showed a large amount of albumin, and the sediment consisted of masses of almost black, coarse and finely granular amorphous material. There were no erythrocytes but clumps of red material. Many pus cells were present and the occult blood test gave a strongly positive reaction. Two subsequent transfusions were given without a reaction and without altering the patient's condition. On the day after the transfusion jaundice, stupor, nausea and vomiting developed. Hemoglobinuria persisted.

When the patient was first seen by one of us, three days after the transfusion, the following observations were made: The patient was obese and was critically ill; there were Kussmaul breathing, an odor of acetone on the breath, a blood pressure of 190 systolic and 100 diastolic, stupor, generalized edema, extreme pallor, moderate icterus, cyanosis, nitrogen retention (a nonprotein nitrogen level of 100 mg. per hundred cubic centimeters), acidosis (combining power of carbon dioxide 30 per cent by volume) and hemoglobinuria. The leukocyte count was 19,750. There were edema of both heads of the optic nerve, edema of the retina and a few rather large scattered hemorrhages in both eyes. The retinal arteries appeared normal. In both flanks and extending forward in the abdomen an indefinite mass was palpable which may have been the liver and spleen, but polycystic kidneys had to be considered. The patient was suffering from renal insufficiency following a transfusion, which we thought might be superimposed on polycystic disease of the kidneys.

In spite of massive quantities of physiologic solution of sodium chloride and hypertonic dextrose given intravenously only 1,140 cc. of urine was excreted from the time of the transfusion to death four days later. The nonprotein nitrogen level rose to 112 mg. per hundred cubic centimeters, the combining power of carbon dioxide fell to 24 per cent by volume, deep coma supervened and death occurred four days after the transfusion.

Rematching of the blood of the patient and of the donor was not done.

Fig. 4 (case 3).—Extreme leukocytic infiltration and interstitial edema. Reduced from a photomicrograph with a magnification of 87 diameters.

Autopsy by Dr. J. W. Lindsay gave the following information: The pericardium contained 75 cc. of straw-colored fluid. The heart was normal. Both lungs were congested and edematous. The spleen was enlarged and considerably congested. The liver was enlarged and showed extensive congestion. The right kidney weighed 425 Gm., and the pelvis was dilated. The left kidney weighed 375 Gm. Sections of the kidney showed the tubules generally dilated and containing granular or hyaline material. The tubular epithelium was compressed, and the nuclei were sometimes lost. The proximal tubules were usually dilated. The lining cells were swollen, granular and at times desquamated. Aside from the tubules containing hyaline material, there were others distended with masses of leukocytes and granular material. The glomeruli were well preserved. In some areas there was considerable interstitial edema and some hemorrhagic infiltration. There was extensive leukocytic infiltration, in places appearing like well defined small abscesses (fig. 5). Sections of the liver and spleen showed congestion only.

CASE 5.—B. R., a white woman aged 43, admitted to Garfield Hospital in shock from massive hemorrhage following a spontaneous abortion, was given a transfusion of 500 cc. of citrated blood after curettement and packing of the uterus. The blood of the donor and of the recipient was type III (Moss), and cross agglutination showed no incompatibility. During the transfusion palpitation, oppression, flushing, nausea and vomiting developed, but in spite of this the entire 500 cc. of blood was given. After the transfusion there were chilliness and a mild rise in temperature, and nausea and vomiting persisted. In spite of an adequate parenteral intake of fluids no urine was voided the next day, and on subsequent days, though not measured, the output was known to be inadequate. The urine was not examined. Jaundice was not noted. Four days later another transfusion of 500 cc. of citrated blood was given without reaction. One of us was asked to see the patient seven days after the first transfusion because of continued nausea and vomiting. The urinary output was 270 cc. that day. There were puffiness of the eyes, a blood pressure of 155 systolic and 70 diastolic, normal fundi and an otherwise unrevealing physical examination. The urine was found to contain a large

11. Stetson, R. E.: Personal communication to the authors.

amount of albumin but nothing abnormal in the sediment. The nonprotein nitrogen level was 117 mg. per hundred cubic centimeters. With increased injections of physiologic solution of sodium chloride and hypertonic dextrose the output was increased to 1,100 cc. and thereafter gradually rose, but anasarca and Kussmaul breathing, with a nonprotein nitrogen level of 100 mg. and a chloride level of 633 mg. per hundred cubic centimeters and a combining power of carbon dioxide of 26 per cent by volume were found. The leukocyte count was 23,900, with 91 per cent polymorphonuclear leukocytes. After reduction of the intake of fluid diuresis (6,000 cc.) occurred on the twelfth day after the reaction to the transfusion. Recovery was then rapid though marred by severe bilateral suppurative parotitis. On discharge the urine showed a trace of albumin, its specific gravity was fixed, the nonprotein nitrogen level and blood pressure were normal and the phenolsulfonphthalein test showed an excretion of 34 per cent in one hour. At present no evidence of impairment of renal function can be found.

The blood of donor and recipient was rechecked and found to be type III (Moss). On cross matching there was no agglutination, but at the end of twenty minutes all the donor's cells were hemolyzed by the recipient's serum.

Fig. 5 (case 4).—Dilatation of tubules with flattening of the tubular epithelium. There is interstitial edema and extreme leukocytic infiltration. Reduced from a photomicrograph with a magnification of 87 diameters.

Case 6.—B. M., a Negress aged 35, admitted to Emergency Hospital with an obscure abdominal condition on April 25, 1939, was given transfusions on three occasions without a reaction. After an exploratory laparotomy she was given a transfusion of 500 cc. of citrated blood. The blood of the patient and the donor was type IV (Moss), and cross matching was reported as satisfactory. When 350 cc. of blood had been given a shaking chill occurred and the pulse became weak and thready. The transfusion was stopped, but the temperature rose to 106 F. No urine was passed the next day, but on the following day a small amount of red urine containing much albumin and some erythrocytes was voided. The urinary output per day was 150, 350, 900, 600, 500, 700 and 2,100 cc. There was considerable stupor, the pulse was rapid and the patient showed every evidence of being critically ill. The nonprotein nitrogen level rose to 180 mg. and the creatinine level to 7.5 mg. per hundred cubic centimeters. After injection of large quantities of hypertonic dextrose intravenously, diuresis occurred, with rapid improvement in the patient's condition. The nonprotein nitrogen level fell to 38 mg. per hundred cubic centimeters, and the patient recovered.

A recheck of the blood of donor and recipient showed it to be type IV (Moss). On cross matching, the donor's cells were considerably hemolyzed by the recipient's serum at the end of one hour.

Case 7.—C. D., a white woman aged 48, admitted to Garfield Hospital on Dec. 1, 1937, complained of metrorrhagia. The hemoglobin content was 56 per cent and the erythrocytes numbered 3,900,000. The urine contained a large amount of albumin. To control the metrorrhagia a supravaginal hysterectomy was performed on December 3 for a fibroid uterus. Postoperatively she was given 400 cc. of citrated blood without a reaction. The blood of the patient and of the donor were both type IV (Moss), and the cross matching was satisfactory. On December 5 a second transfusion of citrated blood was given from a donor whose blood matched the patient's type. After receiving 100 cc. she complained of pain in the head, abdomen and precordium. The rate of flow was diminished, but the pains became so intense that the transfusion was stopped at 250 cc. A rigor followed. Six hours later she voided 100 cc. of urine, the specimen being discarded without comment by the nurse. The total output of urine for December 6 was a single specimen of 15 cc. obtained by catheter. It was black and contained a large amount of albumin and numerous dark brown casts. Subsequent specimens showed only large amounts of albumin and at times large numbers of white blood cells. After the transfusion there was persistent nausea and vomiting. Large intravenous injections of dextrose and saline solution were given daily. Additional transfusions of citrated blood were given from donors whose bloods were properly typed and matched, without reactions, on December 7, 9, 10, 11 and 12. After the reaction to the transfusion the urinary output per day was 15, 150, 300, 90, 0, 150, 532, 500, 960 and 1,536 cc. On the ninth day after the hemolytic reaction, the nonprotein nitrogen level was 190 mg. per hundred cubic centimeters, the combining power of carbon dioxide 22 per cent by volume and the leukocyte count 12,500 with 76 per cent polymorphonuclears. Coma and anasarca were extreme. Thereafter tremendous quantities of urine were passed, and with the diuresis the edema vanished and the patient improved. By the thirty-fifth day the nonprotein nitrogen level had fallen to 45 mg. per hundred cubic centimeters. The systolic blood pressure never exceeded 162, the diastolic, 100 mm. of mercury.

Convalescence was complicated by a severe infection of the abdominal wound, profuse purulent vaginal drainage, pyelitis and large vaginal hemorrhages necessitating a further transfusion of 500 cc. of citrated blood. To this transfusion there was a reaction with urticaria and chilly sensations. The patient was discharged on Jan. 28, 1938, fifty-four days after the causative transfusion. On subsequent observations, the last on April 1, 1940, the patient has been found to be in excellent condition; the examinations of urine gave negative results; the blood pressure readings were within normal range and the phenolsulfonphthalein excretion was normal. The blood of the donor and patient was rechecked. The blood of the donor was found to be type II and that of the recipient type IV (Moss). On cross matching there was agglutination and hemolysis of the donor's cells.

Case 8.—J. E., a white woman aged 61, was admitted to Garfield Hospital on June 7, 1938 for splenectomy for Banti's disease. There was extreme anemia. The urine showed a large amount of albumin and a few granular casts. The nonprotein nitrogen level was 37 mg. per hundred cubic centimeters. The blood pressure was 150 systolic and 84 diastolic. Repeated transfusions were given. On July 12 before reacting from anesthesia, she was given a transfusion of 250 cc. of citrated blood. The patient's blood was type IV (Moss), as was the donor's. Cross matching showed no incompatibility. During the transfusion the patient became restless and tossed about in bed. The daily intake for six days after the transfusion was 2,610, 3,540, 3,330, 3,600, 4,350 and 2,230 cc. with a daily output of 525, 585, 630, 930, 1,620 and 2,535. The character of the urine was not remarked on. Listlessness developed three days after the transfusion, and gradually the patient became stuporous, disoriented and incontinent. The leukocyte count was 22,800, with 81 per cent polymorphonuclears. Two weeks later, though the urinary output had become satisfactory, the nonprotein nitrogen level rose to 112 and soon afterward

to 150 mg. per hundred cubic centimeters. There it remained for several days. Gradually with symptomatic improvement the nitrogen level returned to normal. No recheck of the blood grouping or cross matching was done.

CASE 9.—A. L. C., a white woman aged 35, admitted to Emergency Hospital on Sept. 1, 1938, complained of chronic glomerular nephritis and purpura. During a previous admission to the hospital she had had three transfusions with a pronounced reaction consisting of chill, fever and persistent nausea with vomiting following one of them. The blood pressure was 170 systolic and 98 diastolic. The urine was of low, fixed specific gravity and contained albumin. The nonprotein nitrogen level was 76 mg. per hundred cubic centimeters. On September 16, though her condition was improved and she was ready for discharge, she was given a transfusion of 500 cc. of citrated blood from the same donor whose blood had produced a reaction during the previous admission. The patient's blood was type IV (Moss), as was the donor's. Cross matching showed no incompatibility. Fifteen minutes after completion of the transfusion lumbar and precordial pain, rapid pulse, a chill, fever, nausea and vomiting developed. The following morning the patient passed 160 cc. of red urine which contained a large amount of albumin and many erythrocytes and gave a strongly positive reaction to benzidine. The blood pressure fell to 104 systolic and 70 diastolic, and depletion was marked. Jaundice was not noted. Stupor with oliguria was accompanied by a rise of the nonprotein nitrogen level to 112 mg. and of creatinine to 5 mg. per hundred cubic centimeters. There was no leukocytosis. Large amounts of 10 per cent dextrose in physiologic solution of sodium chloride were administered by vein. After a week of pronounced oliguria, diuresis occurred and the patient's condition returned to what it had been before transfusion. The nonprotein nitrogen had returned to its previous level when she was discharged from the hospital. Fourteen months later she was readmitted to the hospital with anasarca and uremia, dying soon after admission. Autopsy showed small, contracted kidneys with the usual microscopic appearance of chronic glomerular nephritis. There was no recheck of the blood grouping or cross matching.

CASE 10.—M. F., a white man aged 19, admitted to Gallinger Hospital on April 6, 1939, had fractures of the left forearm and left femur. These extremities were in casts. The patient was ill with fever. On removal of the casts multiple draining sinuses were found and roentgenograms showed extensive osteomyelitis. Multiple drainage was instituted and he received during a three months period ten transfusions of stored blood without a reaction. On Aug. 13, 1938 he was given 500 cc. of warmed stored blood which was 8 days old and partially hemolyzed. Thirty minutes after the transfusion he had a severe, shaking chill and gradually became drowsy and irrational. That evening he voided a small amount of mahogany-colored urine containing albumin, hemoglobin and some erythrocytes. A smaller amount of urine of the same character was passed the day after the transfusion, but no further urine was voided. Jaundice was noted, and the van den Bergh test gave an immediate direct reaction. On the third day after the transfusion stupor was more pronounced and the nonprotein nitrogen level was 85 mg. per hundred cubic centimeters. The patient died on August 16, three days after the transfusion, in spite of large amounts of fluids and alkalis administered parenterally. Permission for autopsy was not obtained. A reexamination of the donor's and of the patient's blood showed no incompatibility.

TABLE 1.—*Summary of Clinical Data*

Case	Age and Sex	Diagnosis	Blood Type (Moss) Patient's	Blood Type (Moss) Donor's	Amount of Blood, Cc., and Method	Immediate Reaction	Leukocytes	Polymorphonuclears, per Cent	Nonprotein Nitrogen	Carbon Dioxide Combining Power	Outcome and Day of Death or Climax	Recheck	Proved Incompatible	Proved Compatible	Comment
1	63 ♀	Pernicious anemia	Not typed		500 citrate	Yes	30,850	75	160	33	Died 5 days	No	....	....	Autopsy
2	28 ♀	Abortion	IV	IV	550 citrate	?	19,100	80	100	..	Died 8 days	Yes	....	Yes	Autopsy
3	50 ♀	Fractured hip	IV	IV	500 whole 200 citrate	?	30,000	90	90	31	Died 13 days	Yes	Yes	....	Autopsy
4	26 ♀	Postpartum bleeding	IV	IV	500 citrate	No	19,750	..	112	24	Died 4 days	No	....	....	Autopsy
5	43 ♀	Abortion	III	III	500 citrate	Yes	22,900	91	100	26	Recovery 7 days	Yes	Yes		
6	35 ♀	Undetermined	IV	IV	350 citrate	Yes	17,000	86	180	..	Recovery 3 days	Yes	Yes		
7	48 ♀	Uterine bleeding	IV	IV	250 citrate	Yes	12,500	76	100	22	Recovery 8 days	Yes	Yes		
8	61 ♀	Banti's disease	IV	IV	250 citrate	Yes	22,800	81	150	..	Recovery 3 days	No			
9	55 ♀	Chronic nephritis	IV	IV	500 citrate	No	.....	..	120	..	Recovery 7 days	No			
10	19 ♂	Osteomyelitis	I	I	500 citrate	No	.....	..	85	..	Died 2 days	Yes	....	Yes	Hemolyzed blood bank
11	25 ♀	Abortion	Not typed		500 citrate	No	18,200	75	...	..	Died 9 days	No			
12	32 ♀	Abortion	II	IV	500 citrate	No	74,000	95	...	..	Died 6 days	No			
13	35 ♀	Banti's disease	II	II	500 citrate	Yes	10,300	90	100	..	Recovery 7 days	No			

Cross matching was satisfactory in all cases.

Case 10 is thought to represent a death due to the use of hemolyzed stored blood which was probably warmed to an excessive temperature.

CASE 11.—I. F., a white woman aged 25, admitted to Garfield Hospital July 13, 1932, had a hemorrhage from a spontaneous abortion. She was acutely ill, with a temperature of 103 F. The hemoglobin content of the blood was 29 per cent. The erythrocyte count was 2,200,000 and the leukocyte count 10,300. The urine showed a slight amount of albumin. After manual removal of the retained placenta her condition was improved. A transfusion of 500 cc. of citrated blood was given. Cross matching was satisfactory, but no blood typing was done. The transfusion was followed by a thermal reaction. On July 22 a second transfusion of 500 cc. of citrated blood was given. There was no typing, but cross matching was satisfactory. One half hour later there were a severe chill, involuntary defecation and a temperature of 105.6 F., and vomiting began. The following morning there was definite jaundice and 500 cc. of urine was voided, the character not being recorded. On the second day, the urinary output was 390 cc. and the fluid intake 2,000 cc. On the third day after the transfusion 450 cc. of dark brown urine was voided. This contained a large amount

of albumin and numerous leukocytes. The leukocyte count was 18,200. During the next six days the patient's condition grew gradually worse with increasing stupor. The daily output of urine totaled 90, 210, 200, 200 and 60 cc. Death occurred on July 31, nine days after the second transfusion. No blood typing or recheck of the cross matching was done.

CASE 12.—C. D., a white woman aged 32, entered Sibley Hospital June 1, 1939 with profuse bleeding from a spontaneous abortion. On this day she received 500 cc. of citrated blood by transfusion. The donor's blood was type IV (Moss) and the patient's type II (Moss). Cross matching was reported as satisfactory. Shortly after the transfusion a severe chill occurred, and the temperature rose to 103.2 F. During the chill there was involuntary defecation and vomiting, and the patient complained of severe pains throughout the body. The following day jaundice was noted, and 550 cc. of urine was voided. No note was made of the character of the urine. The second day after the transfusion the patient's condition was much worse. There were drowsiness and inability to take food. Rales developed at the bases of both lungs. Only 60 cc. of dark brown urine was voided. This contained albumin (4 plus), many granular casts and a few leukocytes and erythrocytes. The leukocyte count was 74,000, with 95 per cent polymorphonuclears. During the subsequent three days the daily urinary output was 100, 210 and 240 cc., despite a daily intake of 3,000 cc. of fluid. On the fourth and fifth days she received transfusions of 300 cc. of citrated blood from type II (Moss) donors without reaction. Death occurred on June 7, six days after the initial transfusion. Permission for autopsy was not obtained. No recheck of the typing or cross matching was done.

TABLE 2.—*Incidence of Various Findings*

Number of cases	13	Edema	6
Immediate reaction	6	Retinal hemorrhages	2
Nausea and vomiting	11	Leukocytosis (of 11 recorded)	11
Hemoglobinuria	11	Proved incompatible (of 6 rechecked)	4
Jaundice	8	Proved compatible (of 6 rechecked)	2
Stupor	11	Deaths	7
Oliguria	13	Recovery	6
Hypertension (of 7 in which blood pressure was recorded)	4	Mortality	54%

CASE 13.—F. S., a white woman aged 35, admitted to Providence Hospital Jan. 6, 1940, had Banti's disease. There were anemia, splenomegaly and leukopenia. On the day she was admitted a transfusion of 500 cc. of citrated blood was given. The blood of both donor and recipient was type II (Moss), and cross matching was reported satisfactory. After 150 cc. of blood had been given she experienced sharp pain in the upper part of the left side of the abdomen and in the left lumbar region. There was a sense of suffocation, and nausea developed. In spite of the severe reaction the operator gave the rest of the 500 cc. of blood. One-half hour later there were pronounced restlessness, weeping, general malaise and a temperature of 101 F. The following day jaundice was noted and vomiting was pronounced. No urine was voided. The second day after the transfusion 90 cc. of dark urine was voided after an intake of 2,000 cc. of fluid. The urine contained albumin (4 plus), occasional granular casts, many erythrocytes and leukocytes. The leukocyte count was 10,300 with 90 per cent granulocytes. The daily output of urine for the next five days was 60, 45, 180, 180 and 520 cc., with a daily intake of approximately 2,000 cc. of fluid. Vomiting continued. Rales appeared at the bases of the lungs. The blood pressure rose to 180 systolic and 70 diastolic, and on the sixth day after the transfusion the nonprotein nitrogen level of the blood was 109 mg. and the creatinine level 6 mg. per hundred cubic centimeters. On the eighth day after the transfusion, gradual diuresis began, associated with definite improvement in the patient's condition. The daily urinary output was 825, 930, 1,150, 1,890, 2,400 and 2,600 cc. The nonprotein nitrogen level fell to 33 mg. per hundred cubic centimeters nineteen days after the transfusion. Five weeks after the transfusion a successful splenectomy was performed before which four transfusions of 500 cc. of citrated blood were given without a reaction. There was no recheck of the blood typing or cross matching.

COMMENT

The accompanying tables summarize the observations on our 13 cases. The blood of 7 of the patients was type IV (Moss). In 2 of the cases no blood grouping was done, but in all 13 cross agglutination tests between the recipient and the donor were reported as satisfactory prior to the transfusion. Reexaminations of the blood grouping and cross matching were obtained in 6 patients after the reaction to the transfusion. We are personally satisfied as to the thoroughness of the recheck in 4 of these cases. The blood of donor and recipient in these were all incompatible. In the 2 other cases there was no evidence of incompatibility. One of these patients was given warmed, hemolyzed blood which had remained in the bank for eight days. Baker[12] has reported an instance of renal insufficiency probably due to overheating blood with resultant hemolysis. DeGowin's[13] recent work seems to indicate that the warming of blood prior to administration adds a hazard to the procedure. He finds that cold blood can be given with complete safety. In case 2, 24 hour old stored blood was used, but careful cross matching and retyping by two different laboratories failed to furnish any evidence of incompatibility. We did not have an opportunity personally to recheck this blood.

Moss[4] in 1910 said: "Isoagglutination may occur independently of isohemolysis but isohemolysis is probably always preceded or accompanied by isoagglutination." Cases 5 and 6 of our series indicate that this generalization is not tenable, as in both these cases hemolysis of the donor's cells occurred without concomitant agglutination. Bernheim,[14] Kolmer[15] and DeGowin and Baldridge[16] have found, too, that hemolysis of the donor's cells by the recipient's serum is not necessarily preceded or accompanied by agglutination. It seems apparent, therefore, that our present routine examinations for compatibility between the donor's cells and the recipient's serum is inadequate and therefore does not always prevent the use of incompatible blood. We feel that the usual cross matching preparations should be incubated for one hour at 37.5 C. and that tube preparations by the Landsteiner technic[2] should be employed.

It has been clearly shown by Strumia and others[17] that citrated plasma is as valuable as whole blood in combating secondary shock. It is, therefore, unnecessary to give emergency transfusions if a plasma bank is maintained. The use of plasma will avoid the necessity of hurried typing by persons of little experience and thereby prevent serious or fatal reactions.

Experimental work with animals[18] indicates that renal failure does not occur when hemoglobin is trans-

12. Baker, S. L.: Urinary Suppression Following Blood Transfusion, with Report on a Case Probably Due to Overheating the Blood, Lancet 1:1390 (June 12) 1937.

13. DeGowin, E. L.; Hardin, R. C., and Swanson, L. W.: Transfusion of Cold Blood in Man, J. A. M. A. 114:859 (March 9) 1940.

14. Bernheim, B. M.: Blood Transfusion, Philadelphia, J. B. Lippincott Company, 1917, p. 54.

15. Kolmer, J. A.: Isohemolysins in the Blood Without Isoagglutinins, J. A. M. A. 73:1459 (Nov. 8) 1919.

16. DeGowin, E. L., and Baldridge, C. W.: Fatal Anuria Following Transfusion: Inadequacy of Present Tests for Compatibility, Am. J. M. Sc. 188:555 (Oct.) 1934.

17. Strumia, M. M.; Wagner, J. A., and Monaghan, J. F.: The Use of Citrated Plasma in the Treatment of Secondary Shock, J. A. M. A. 114:1337 (April 6) 1940.

18. Baker and Dodds.[3] DeGowin, Osterhagen and Andersch.[5]

fused if the urine of the recipient animal is alkaline. It therefore seems desirable to give alkalis to all patients prior to transfusion.

Immediate reactions occurred in 6 of our cases, but in only 2 of these was the operator wise enough to stop the transfusion before the intended amount of blood had been given. One patient received 350 cc. and the other 250 cc. of blood. Both recovered, as did the 1 other patient who received less than 350 cc. of blood. This seems to indicate that there is a correlation between the outcome and the amount of blood given.

We have been impressed by the frequency and persistence of nausea and vomiting. In 2 patients these symptoms occurred as an immediate reaction. Involuntary defecation occurred in 3 of the 6 patients experiencing an immediate reaction. Hemoglobinuria developed in 11 patients, jaundice in 8, stupor in 11, edema in 6 and oliguria in all 13 patients. Retinal hemorrhages were found in 2 instances though there is no record of examination of the fundus in the majority of the cases. Of the 7 patients on whom observations of blood pressure were recorded after the reaction, 4 had hypertension. Azotemia and acidosis existed in all the cases studied. No correlation could be found between these and the ultimate outcome.

The frequency of leukocytosis has not been previously emphasized. It was present in all 11 cases in which the leukocytes were counted after the reaction. The leukocyte counts ranged from 10,000 to 74,000 per cubic millimeter, with an average of 25,000. In the great majority of instances there was a significant increase in the polymorphonuclear leukocytes with a shift to the left in the Schilling index. The striking leukocytosis is not unlike that seen in poisoning with mercury bichloride, in which there is also extreme damage to the renal tubules. We find no prognostic value in the level of the leukocyte count.

There were 7 deaths among the 13 patients, a mortality of 54 per cent. The duration of life after onset of the condition in the fatal cases ranged from three to thirteen days. In the nonfatal group diuresis began in from three to nine days after the transfusion.

Permission for autopsy was obtained in 4 of the 7 fatal cases. In all instances the kidneys were large, swollen and congested. The sections all showed interstitial edema, leukocytic infiltration, dilatation of the tubules and degenerative changes of the tubular epithelium. In 2 cases the tubules were filled with enormous quantities of reddish brown, granular pigment, probably acid hematin. The microscopic picture in those 2 cases strikingly resembles the change produced experimentally in dogs by DeGowin.[10] In the other two there was some deposition of granular and hyalinized material in some of the tubules. In only 1 instance was there necrosis of the liver cells about the central veins. The liver showed considerable congestion in the remaining 3 cases. The pathologic examinations confirm the observations of Bordley, DeGowin and others but add nothing to our knowledge of the pathogenesis of the lesions.

CONCLUSIONS

Among 13 patients with renal insufficiency following transfusion 6 recovered and 7 died.

An immediate or delayed reaction occurred as a result of the transfusion and was followed by nausea, vomiting, hemoglobinuria, jaundice, oliguria, stupor and uremia.

Leukocytosis was present in all cases in which the leukocytes were counted.

Of 6 cases in which the blood grouping and cross matching were rechecked the blood in 4 was shown to be definitely incompatible. Of the remaining 2, in 1 warmed, hemolyzed, stored blood 8 days old was given.

Isohemolysis unaccompanied by isoagglutination was found in 2 cases. This accounted for the error in cross matching and caused the hemolytic reaction.

More careful cross matching of the blood of donor and recipient by the use of tube preparations incubated at 37.5 C. for one hour will prevent some of the errors and save lives.

Citrated plasma should probably replace whole blood in the treatment of secondary shock and hemorrhage.

Alkalis should be administered to all patients prior to transfusion.

The pathologic changes in the kidneys in 4 fatal cases consisted of interstitial edema, leukocytic infiltration, degeneration and necrosis of the tubular epithelium and the deposition in the renal tubules of granular pigment derived from hemoglobin. One case showed central, focal necrosis of the liver cells.

1726 Eye Street.

Clinical Notes, Suggestions and New Instruments

TRAUMATIC IMPLANTATION OF EPITHELIAL CYST IN A PHALANX

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The occurrence of an epithelial cyst enclosed within the bony structure of a phalanx of a finger is a rare condition, for such a case has not been reported in the medical literature of this country. Neither can it be found mentioned in the recent textbooks of general and orthopedic surgery, of tumors and also of bone diseases. So to present a case in which it was found should be of interest. An explanation of its origin embraces two possibilities: first, that of congenital malformation with inclusion of aberrant epithelial cells, comparable to the formation of a simple dermoid cyst; second, that of traumatic implantation.

CASES REPORTED

Five cases have been found recorded in the European medical literature; this presentation makes a sixth case, the first in America.

The first recorded was one by Sonntag[1] in 1923: A young female injured the left hand in a machine, crushing the terminal phalanx and the distal part of the middle phalanx, which necessitated an amputation at the distal end of the middle phalanx. Twenty-four years later, after several minor injuries, there developed a swelling in the end of the stump, which was thought to be, clinically and by roentgen examination, a sarcoma. Histologically, however, it proved to be an epithelial cyst, supposedly of traumatic origin.

Burrows' case,[2] reported in 1926, was that of a man aged 47. When only 11 years old he ran a piece of wire deeply into the left thumb, but he did not know whether the wire went into the bone or not. In 1925, thirty-five years after the injury, he noticed that the end of this thumb was swollen. Then six months later a piece of metal fell on his thumb, which became tender and painful. On examination the thumb

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Mr. George Mollo of the Research Department of the Forstmann Woolen Company, Garfield, N. J., assisted in the preparation of the photomicrographs.

1. Sonntag: Traumatische Epithelzysten im Knochenende an einem Fingerstumpf als Unfallfolge, München. med. Wchnschr. 70: 1055-1056 (Aug. 10) 1923.

2. Burrows, H.: Implantation Dermoid of Terminal Phalanx of Thumb, Brit. J. Surg. 13: 761-762 (April) 1926 (illustrated).

was swollen, reddened, tender and hot to the touch. Roentgen examination showed the terminal phalanx occupied almost completely by a ramifying cyst. At the operation a lateral incision was made, and immediately under the skin there was found a mass of white material resembling hydrous wool fat, which was pure white. This mass almost completely surrounded the phalanx and was not enclosed by a cyst wall. The terminal phalanx was amputated. Examination of the specimen showed that the bone was occupied by a single ramifying cyst with a white glistening lining. The wall was formed by a dense, almost acellular, fibrous tissue lined by stratified epithelium, which showed a prickle cell layer and stratum granulosum, and no papillae. The tissues showed no evidence of inflammation. The diagnosis was an implantation dermoid cyst which had been ruptured by a direct injury, thus becoming diffused.

Friedländer's case,[3] reported in 1930, was that of a boy aged 13 years who had injured his left index finger one year previously on the spokes of a bicycle wheel. Several months later the finger began to swell, but there was little pain. Roentgen examination revealed a transparent cyst occupying two thirds of the distal phalanx with a very thin covering of unbroken cortical bone. Amputation was performed at the distal joint. The specimen showed a smooth cyst with a clear lining and contents of a yellowish flaked material. The inner lining of the cyst was that of a keratinized epidermis which lacked continuity in one place where there was intermingling granulation tissue, giant cells and some squamous epithelial cells.

Hammann's cases,[4] reported in 1930, was that of a man aged 31 who had injured his right hand sixteen years before. The right index finger had been struck with a hammer. The skin was lacerated and the nail bed was injured. At that time the nail was removed and the wound healed without infection. Later the nail regrew. One year previously, the finger began to swell and hurt whenever it was struck. The roentgenogram showed the following: In the anteroposterior

Fig. 1.—Epithelial cyst within the terminal phalanx: *A*, anteroposterior view; *B*, lateral view.

view of the terminal phalanx there appeared a small cystic homogeneous transparent mass destroying the bone on the radial side. On the ulnar side there was normal bone from 2 to 3 mm. in thickness. In the lateral view the cyst occupied the bone completely under the nail bed, while on the volar surface there was a 3 mm. thickness of normal bone. At operation a lateral incision was made, the cyst dissected out, the bone curetted and the wound closed. The specimen was that of a small white round tumor distinctly encapsulated and forming a cyst lined with epithelium and having its contents partly encrusted with calcium. About one fourth of the epithelial lining was thickened and showed a typical stratified structure.

Fig. 2.—Section of epithelial cyst from phalanx showing stratified layers and dense keratinized contents.

Behrens[5] in 1931 reported the examination of a specimen sent to him by Valentin. This had been removed from the terminal phalanx of the right fifth finger of a man. In 1918 he had had a slight injury to the finger by a shell splinter. In 1923 he had again injured it, this time splitting the nail bed. In 1929 it became painful and swollen, and the terminal phalanx was amputated. On examination the specimen showed an epithelial cyst in the phalanx underneath the nail bed with a granuloma protruding from the bone underneath the nail.

REPORT OF CASE

History.—A woman aged 39, seen in January 1940, had two years previously injured the terminal phalanx of her right fourth finger by catching it in an orange juice mixer. There was a laceration, and the nail was almost completely avulsed. She was treated at that time in the dispensary. The nail was removed and the finger was dressed. There was no complication by infection. The finger healed completely and the nail regenerated. She noticed a slight swelling of the end of the finger for several months. For the past three weeks there had been moderate pain, especially when the finger was struck.

Summary of Five Cases in Literature

Name	Previous Injury, Years	Finger Affected	Phalanx Affected	Pain	Swelling	Cyst	Cortex Broken
Sonntag	24	4th	Middle	+	+	..	..
Burrows	36	1st	Distal	..	+	+	..
Friedländer	1	2d	Distal	+	+	+	+
Hammann	16	2d	Distal	+	+	+	+
Behrens	13	5th	Distal	+	+	..	..

Examination and Treatment.—Examination revealed diffuse swelling of the soft tissue at the terminal phalanx of the right fourth finger. Deep pressure was painful but superficial pressure on the soft tissues caused no pain. There was no redness and no local heat. Motion was normal. A roentgenogram (fig. 1), taken January 8, revealed the following: In the anteroposterior view there was a circular area of destruction of the cortex of the terminal phalanx of the right fourth finger, well localized and transparent. The lateral view showed that the destructive process had penetrated the periosteum on the radial side of the phalanx and that there was some swelling

3. Friedländer, C.: Tumors, Dermoid: Traumatic Epithelial Cyst in Terminal Phalanx of Forefinger; Case, Zentralbl. f. Chir. **57**: 209-212 (Jan. 25) 1930.

4. Hammann: Tumors, Dermoid: Traumatic Epithelial Cysts of Phalanges of Hand, Deutsche Ztschr. f. Chir. **223**: 308-317, 1930.

5. Behrens, A.: Traumatic Epithelial (Dermoid) Cysts: Three Cases, Virchows Arch. f. path. Anat. **280**: 145-151, 1931.

of the soft tissues. At operation, January 11, under ethylene anesthesia, an incision was made on the lateral surface of the terminal phalanx curving over the tip. The incision was carried down to the bone, which was easily entered with a fine chisel. When a fine curet was inserted into the cavity of the bone a small white mass popped out. There was no pus present. A culture was taken of material from the wound and the cavity in the bone was curetted gently and thoroughly. A small petrolatum pack was inserted into the bone cavity and the wound was closed. Five days later the petrolatum drain was removed, and the wound healed subsequently without any discharge. The culture taken from the finger showed no growth.

Pathologic Report.—The specimen consisted of a small mass of soft tissue from the distal phalanx of the fourth finger of the right hand. It measured 0.5 cm. in diameter, and the external surface gave the appearance of distinct encapsulation.

Microscopic examination (fig. 2) showed a thin wall formed by stratified squamous epithelium surrounding a nest of keratin débris, in the formation of which there was no parakeratosis. The stratum granulosum and rete mucosum were thick. The basal layer did not accompany these except in one place, where only a minute fragment was attached.

Postoperative Course.—The end of the finger remained slightly enlarged but was not tender. The patient was discharged, to return to the outpatient department. Roentgen examination at the time of discharge was the same as the first except that it demonstrated a fracture line through the external wall of the phalanx which was the point of entry of the curet at the operation.

SECOND ADMISSION

In June, five months later, the patient returned complaining that there had been gradually increasing tenderness of the finger but no increase in swelling. Roentgen examination (fig. 3) revealed that the fracture line showed no evidence of callus formation, and the general appearance of the lesion was similar to that found originally. Accordingly it was decided to excise the distal half of the phalanx. Under gas-ether anesthesia a U-shaped incision was made over the tip of the finger, and the distal half of the phalanx was excised. The pathologic specimen presented a piece of osseous tissue measuring 9 by 7

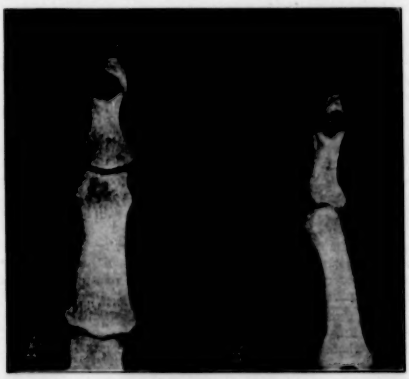

Fig. 3.—*A*, anteroposterior view, and *B*, lateral view, showing no evidence of callus formation of the fracture line after the first excision.

by 4 mm. which had the consistency of normal bone. Lying within a cavity in this portion of bone was a piece of whitish hairlike tissue which had the consistency of a heavy rubber ball, and it measured 4 mm. in diameter. This was easily shelled out of the phalanx. Microscopically the cyst presented exactly the same picture as the previous one. The portion of the phalanx, microscopically, presented marked congestion of the vascular net of bone marrow, and around the circumference of the cystic opening there was a mild degree of osteitis.

The wound healed without any trouble. The swelling of the finger gradually decreased. Roentgen examination (fig. 4) at the time of the discharge two months later showed an amputation of the distal half of the phalanx and no evidence of pathologic changes in the remaining portion of the bone.

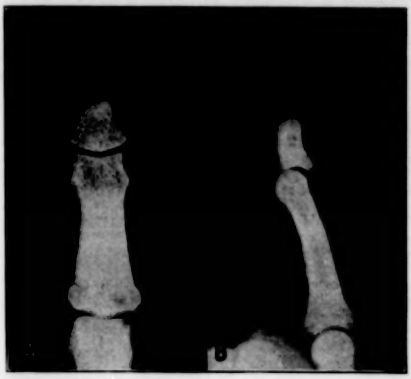

Fig. 4.—Amputation of the distal half of the phalanx: *A*, anteroposterior view; *B*, lateral view.

COMMENT

Every case, including the one reported here, presented a history of trauma, and it was either a penetrating one or a crushing one, damaging the nail bed. In 2 cases subsequent injuries caused rupture of the bone tumor and encroachment by it into the soft tissues.

These cysts, although within the bone, were like the implantation cysts that have been found in the soft tissues of the palmar surfaces of the fingers and hand, especially in tailors and seamstresses, as noted by Long.[6] So a discussion of the means of implantation of the subcutaneous cysts would be applicable to these bone cysts. There are presented two different theories concerning their etiology: Friedländer claims that there is a congenital maldevelopment with embryonal misplacement of epithelial cells into the bone and that these are stimulated to growth by the injury. Franke[7] agrees that the cysts are of congenital origin but holds that trauma is not essential as an exciting stimulus. On the other hand, Reverdin[8] and Garré[9] emphasize the presence of trauma in every case and believe that the epithelial cells are implanted at the time of the injury. This view is supported by the experimental work of Schweninger[10] and Kaufmann,[11] who succeeded in growing epithelial cysts after transmitting epithelial tissue into the cock's comb. Wörz[12] presents a case in which an epithelial cyst developed subcutaneously from a Thiersch skin graft around an injured ulnar nerve. Pels-Leusden[13] and Hesse[14] also disagree with Franke concerning the idea of

6. Long, J. H.: Dermoids, Am. Med. **5**: 530-533, 1910.
7. Franke: Ueber Epidermoide (sogenannte Epithelcysten), Deutsche Ztschr. f. Chir. **40**, 1895.
8. Reverdin, J. L., and Mayor, A.: Des kystes epidermiques des doigts, Rev. méd. de la Suisse Rom. **7**: 121-139, 1887.
9. Garré, C.: Ueber traumatische Epithelcysten der Finger, Wien. med. Bl. **17**: 27-29, 1894.
10. Schweninger: Beitrag zur experimentellen Erzeugung von Hautgeschwülsten, Charité-Ann. **11**: 642, 1886.
11. Kaufmann: Ueber Enkatarrhapie von Epithel, Virchows Arch. f. path. Anat. **97**, 1884; Ueber experimentelle Erzeugung von Atheromen, ibid. **107**, 1887.
12. Wörz, A.: Ueber traumatische Epithelcysten, Beitr. z. klin. Chir. **18**: 753, 764, 1897.
13. Pels-Leusden: Ueber abnorme Epithelisierung und traumatische Epithelcysten, Deutsche med. Wchnschr. **31**: 1340-1342, 1905.
14. Hesse, F. A.: Die Enstehung der traumatischen Epithelcysten, zugleich eine kritische Studie über die Atheromliteratur, Beitr. z. klin. Chir. **80**: 494-545, 1912.

congenital origin. They demonstrated by experiments that injury to the deep appendages of the skin, even without breaking the continuity of the skin, can cause epithelial cysts to form in the subcutaneous tissue. Hammann, on reviewing the literature, also emphasizes his belief in the traumatic origin. He stated that there had never been observed congenital cysts of the hand and fingers and that therefore it is a misnomer to consider them as genuine dermoids, such as those found in the region of the eye and frontal bone. Behrens, discussing his case of epithelial bone cyst, also thinks that trauma had caused a transplantation of the epithelium and reasons that a fracture must have taken place.

In the face of all the evidence, it is difficult to accept the view of congenital origin, for trauma was a constant finding. Since in all cases it was considered relatively slight, no roentgenograms were taken at the time of the original injury to show whether a fracture was present or not. In Sonntag's case the bone was definitely injured, presenting a clearcut channel for the implantation of the epithelium. It is known that the epithelial cell is a hardy one and an actively growing one. It has a remarkable ability to regenerate under conditions that would be unfavorable for growth of other more specialized tissues, as exemplified by the comparative ease of surface wound healing and grafting of skin. It is also significant that none of these tumors presented evidence of sweat and sebaceous glands or hair follicles. It is well known that surface epithelium, when it does regenerate, produces a smooth layer of cells without reformation of any specialized epidermal structure. We feel, therefore, that these tumors are caused by the implantation of epithelial cells into the bone as a result of the injury. This could take place through the smallest kind of a fracture or even by transmission along the vascular channels. It is further significant that in all cases the lack of infection is noted. If infection had taken place at the time of the original injury, the epidermal cells could not have survived. They would have been destroyed by the infectious process and extruded in the process of repair.

In all the cases the tumor grew from within the bone, destroying and thinning the cortex by pressure necrosis. In 2 cases, following a second injury, the cortex was broken through and the tumor encroached on the soft tissues of the finger. The rate of growth of the tumor appears to be quite slow. In 4 cases the injury was sustained from thirteen to fourteen years before the appearance of symptoms, while in Friedländer's case the interval was one year and in our case two years. The pathologic picture was the same in all cases. Grossly the tumors consisted of a whitish, well circumscribed, encapsulated mass of soft tissue not adherent to and easily separated from the bone. Microscopically it showed well defined stratified squamous epithelium.

It is felt that this tumor has a benign character, although it may recur locally if it is not completely removed, which happened in this case. In respect to the treatment, it is felt that amputation is not necessary, because of the benign character of the tumor, unless it has grown to such a size that it has destroyed a considerable part of the phalanx. Otherwise, simple excision should suffice for a cure. The gross appearance of the tumor is so typical that the character of the growth can be readily recognized at the time it is removed.

SUMMARY AND CONCLUSIONS

1. The occurrence of a stratified squamous epithelial cyst within a phalanx has been recognized in 6 cases.

2. Trauma was present in all the cases.

3. There was no infection complicating the effect of the trauma in any of the cases.

4. The interval between the time of injury and the onset of symptoms was relatively long.

5. The tumor evidently grew from within the bone outward.

6. The macroscopic and microscopic pictures had a marked uniformity in all the cases.

7. No recurrence has been reported following treatment by amputation.

34 Grove Street.

SPERMATIC CORD TUMORS

REPORT OF A FIBROMYXOLIPOMA

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AND
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Reports of neoplasm of the spermatic cord and tunics of the testicle are few, only 247 being on record June 10, 1939, and the current textbooks rarely more than mention it. The accompanying table, a compilation from the literature by Schulte, McDonald and Priestley,[1] shows their number and distribution as to type and malignancy. Since that study was published the *Quarterly Cumulative Index Medicus* has, up to April 1940, listed three other cases of spermatic cord tumor. The present report then brings the total of such tumors to at least 251.

Quinby [2] and a small number of other authors have reported lipofibromyxomas, but the summary table by Schulte and his associates [1] does not list this tumor as such, though it is referred to in the text of their article. Of the spermatic cord tumors, lipomas constitute 36.4 per cent, while those composed of fibrous tissue, the fibromas and fibrosarcomas, make up 19.8 per cent. Some authors list and describe certain growths under the term "mesodermal tumors." Rubaschow [3] in 1926 listed

Tumors of the Spermatic Cord Reported in the Literature

Benign		Malignant	
Lipoma	90	Fibrosarcoma	15
Fibroma	34	Leiomyosarcoma	2
Leiomyoma	3	Rhabdomyosarcoma	2
Myoma	4	Sarcoma	39
Dermoid	14	Reticulosarcoma	1
Teratoma	1	Lymphosarcoma	1
Lymphangioma	5	Myxochondrosarcoma	2
Hemangioma	4	Carcinoma	3
Myxoma	1		65
Myxofibroma (possibly neurogenic)	1	Unclassified	6
Neurofibroma	1	Other mesodermal tumors	17
Cystadenoma	1	Total tumors	247
	159		
Benign tumors, approximately			71 per cent
Malignant tumors, approximately			29 per cent

Compiled by Schulte, McDonald and Priestley.

twenty-seven such tumors in the literature. Other authors divide them into myxolipomas, myxofibromas, myxolipofibromas, myxofibrosarcomas, myxochondrosarcomas and so on. Essentially, the tumors of the spermatic cord are derived from tissues of mesodermal origin. The exceptions are the single case of cystadenoma and the three cases of carcinoma. One may properly ask whether these did not originate from or in a teratoma or some less definite embryonal displacement. Some authors do not give to neoplasms terms that are inclusive of all elements and are content to list a given tumor under its most dominant cell type. This is an especially common procedure when the two or more cell types are derived from the same embryonic layer and are as closely related as fibrous and myxomatous elements.

From a review of the literature, and in reporting forty-one cases of tumors of the spermatic cord, epididymis and testicular tunics, Thompson [4] concluded that approximately 70 per cent of all tumors of the spermatic cord, 40 per cent of tumors of the epididymis and 60 per cent of tumors of the testicular tunics are benign, while tumors of the testis almost without

1. Schulte, T. L.; McDonald, J. R., and Priestley, J. T.: Tumors of the Spermatic Cord: Report of a Case of Neurofibroma, J. A. M. A. **112**: 2405-2406 (June 10) 1939.

2. Quinby, W. C.: Tumors of the Spermatic Cord and Testicular Tunics, Tr. Am. A. Genito-Urin. Surgeons **30**: 385-391, 1937.

3. Rubaschow, S.: Die soliden Geschwülste des Nebenhodens, Ztschr. f. Urol. **20**: 290-297, 1926.

4. Thompson, G. J.: Tumors of the Spermatic Cord, Epididymis and Testicular Tunics: Review of Literature and Report of Forty-One Additional Cases, Surg., Gynec. & Obst. **68**: 712-728 (April) 1936.

exception are highly malignant. Schulte and his associates[1] record essentially the same conclusions for spermatic cord tumors, 71 per cent being benign.

The tumors or tumor-like swellings within the scrotum call for more consideration. The differentiation of tumors of the cord, the epididymis, the testicular tunics and the testicle from developmental defects, traumatic swellings, simple inflammatory lesions (as pyocele or orchitis), tuberculosis, leprosy or syphilis (taking the form of granulomas, spermatoceles, hydroceles, hematoceles and extravaginal hematomas) and hernias is an important one from the standpoint of treatment and prognosis and for the conservation of a masculinization organ, the one source for spermatozoa and certain sex differentiating and activating hormones. A carefully taken clinical history is very important and often leads to the diagnosis. Transillumination is essential, while aspiration of contents followed by physical, cytologic and bacteriologic examinations is commonly the source of a diagnostic finding. The biologic test for gonadotropic substance is necessary for the differentiation of certain testicular tumors and tumors of the spermatic cord. Biopsy, or preferably frozen section diagnosis, is desirable in many cases, and certainly when doubt exists.

REPORT OF CASE

W. G. D., aged 85 and well preserved, has been an outdoor man all his life, active, a farmer accustomed to horseback riding; he still spends several hours weekly in the saddle. He had mumps when he was a boy but there was no associated orchitis; he has never used tobacco or alcoholic beverages in any form. The family history has no bearing on his present condition. He has had no serious illness and has not lost any weight during the last ten years.

Pursuant to fence and tree climbing habits of boyhood days and horseback riding, he recalls many painful experiences of traumatic injury or crushing of the testicles. In the late 1920's a hydrocele or "water seed" of the right side developed. Numerous aspirations resulted in the withdrawal of clear amber colored "beerlike" fluid, and eventually this ceased to form.

During the year 1929 he noticed a swelling of the left side of the scrotum which was not painful. He consulted several physicians from time to time and by aspiration some obtained small quantities of clear fluid, but there has been no permanent benefit. When seen by one of us (J. F. J.) six years ago there was a movable, nontender, painless, firm but compressible tumor, opaque to transillumination beneath the scrotal skin of the left side to which it was not adherent. It appeared to be attached to but not a part of the testicle. At one pole there was a softer area, but on aspiration no fluid was obtained. Surgical removal was advised but the patient withheld consent. Failing to obtain medical relief, the patient resorted to efforts at self aspiration or he had a farmer son introduce a large needle from time to time, and occasionally a little fluid was removed.

The growth slowly increased in size and without pain. With this development the penis became retracted to such a degree that a dimple in the skin represented its opening, and the urinary stream could not be controlled as to direction.

The patient returned to J. F. J. May 22, 1939, following amateur attempts at aspiration, with the tumor in the left side of the scrotum much increased in size, painful and now adherent over an area roughly 4 by 5 cm. to the covering skin, which was a purplish red, thickened, indurated and glistening. He stated that for several days he had had a fever, with soreness, tenderness and pain in the left side of the scrotum. Through the adherent skin slight fluctuation was elicited. The inguinal lymph nodes were not enlarged. The temperature was then 103 F. and the patient was complaining of chilliness and considerable local pain. He was hospitalized and given a pain relieving drug with local applications of alternate cold and heat. For several days there was a septic temperature and the patient appeared quite ill. On June 3 the temperature was 99 F. and under a general anesthetic the tumor mass, surrounded by the tunica vaginalis communis with the attached left testicle and the now adherent portion of inflamed scrotum, was removed in toto. The tumor was continuous upward along the course of the spermatic cord as high as the external inguinal ring. During the preoperative period in the hospital the temperature at one time reached 104.6 F., though on several days the highest recorded was 102.

Other preoperative manifestations were moderate prostatic enlargement, varicosities of the external hemorrhoidal veins, a blood pressure of 150 systolic, 90 diastolic, and negative reactions to the Kahn and Kline tests. The blood picture twenty-four hours prior to operation was erythrocytes 4,950,000, hemoglobin 87 per cent (Sahli) and leukocytes 14,300, with 80 per cent neutrophils and 20 per cent lymphocytes. The urine contained a trace of albumin, an occasional red blood cell and numerous leukocytes, with a rare hyaline cast.

At operation the inguinal canal was not opened and it was found not to be encroached on by the tumor. The entire left scrotal content covered by the tunica vaginalis communis unopened was removed with the portion of scrotum that was adherent to the tumor. The tunica contained some clear, colorless, slightly viscid fluid. The surgical wound was closed except for a space at the lower portion of the scrotum, through which a rubber dam drain was inserted.

A fibromyxolipoma of the spermatic cord. Marginal to the uninvolved testicle is an abscess resulting from self or amateur attempts at aspiration.

Postoperative convalescence was uneventful. The patient left the hospital "on foot" June 16, still showing evidence of a mild infection of the urinary tract.

PATHOLOGIC REPORT

The specimen, M-39-156, weighed 1,425 Gm. and was composed of testicle, tunics and tumor as a mass, measuring 20 by 14 by 8 cm. The tumor, shown in the illustration, was smooth surfaced, well encapsulated and of firm but somewhat rubbery consistency. On surface by section the specimen, which was solid, was composed largely of adipose tissue. The cut surfaces showed strands of connective tissue coursing across the fat, and several small islands of softer, pale, opalescent white, moist, gelatinous structure. At one side was a well circumscribed, encapsulated, grossly normal appearing testicle, and marginal to it but within the tumor was a 4 cm. area of liquefaction necrosis and an accumulation of grayish yellow purulent exudate.

Microscopically the tumor was composed of adipose, fibrous and myxomatous tissues, each of adult appearing well differentiated cellular elements and bearing scant vascular channels. Neither mitotic figures nor areas of marked cellularity could be found. Sections of the testicle showed a slight atrophy of

the acini and a moderate hyperplasia of the interstitial cells of Leydig. The tissue surrounding the abscess was composed of a very heavy cellular wall infiltrated by endothelial leukocytes, many of which contained engulfed fat globules and droplets and some cellular débris. In the central portion of the abscess complete dissolution of normal tissue structure had occurred and there was an invasion by myriads of polymorphonuclear neutrophils.

The diagnosis was fibromyxolipoma of the spermatic cord with an area of necrosis and suppurative inflammation (abscess) and simple atrophy of the testicle with hyperplasia of interstitial cells of mild degree.

The patient when seen on June 18, 1940, appeared to be in good health, but there was urinary retention of from 40 to 50 cc.; urinalysis revealed pyuria of minimal degree, an occasional caudate epithelial cell, a few red blood cells and a trace of albumin but no casts. There was nocturia (three or four times). The prostate was moderately enlarged, compressible and not indurated or fixed, as determined by rectal examination. The blood pressure was 140 systolic, 90 diastolic, and the hemoglobin content and erythrocyte and leukocyte values were within the range of normal.

SUMMARY

A report of a fibromyxolipoma or "mesodermal tumor" of the spermatic cord is added to the twenty-seven reports of such tumors listed by Rubaschow [8] in 1926. There appears to be a need for greater study of the diseases of the testicle, its tunics and the spermatic cord and a more rigid adherence to terminology.

Council on Physical Therapy

THE COUNCIL ON PHYSICAL THERAPY HAS AUTHORIZED PUBLICATION OF THE FOLLOWING ARTICLE. HOWARD A. CARTER, Secretary.

EXPLOSION HAZARD IN ANESTHESIA

Preliminary Statement

Explosion may be caused by anything which can ignite explosive mixtures. They have been caused by hot wire cautery, cutting diathermy knife, x-ray equipment, discharge of static charges with sparking. At least one ether fire was caused by an arc when a plug connector was pulled from its socket while carrying current. The American Society of Anesthetists has assembled over two hundred cases and there are probably other causes, but the aforementioned indicate the more common causes and serve to indicate the nature of reasonable precautions.

Static charges can accumulate only on insulators or insulated conductors, and they may be avoided by the use of shoes with conductive soles and by floors which are conductive and by not insulating operating tables and other fixtures such as the anesthesia apparatus. It has been common practice to wear shoes with soles and heels of rubber or artificial substitutes, all of which insulate the wearer. The use of rubber casters, rubber tired wheels and rubber crutch tips on operating room furniture insulates it. Floors of tile are relatively poor conductors unless specially treated. Floors of linoleum, especially when waxed as usual, are not only insulators but excellent generators of electric charges by friction. Rubber tubing, face masks and breathing bags of anesthesia apparatus are a distinct hazard.

Floors of plain unpainted and unwaxed concrete are usually fairly good conductors from the point of view of this discussion and in modern iron frame buildings give adequate ground connection to leak electricity away so that there will be little likelihood of spark discharge. Most terrazzo floors are sufficiently conductive. Wood floors are entirely unsafe. Experiments indicate that a resistance of a megohm or less to ground for the total circuit will prevent sparks. Tile floors become good conductors when mopped with 4 per cent solution of calcium chloride. No soap should be used on such floors until the calcium chloride has been removed with water; otherwise an insoluble lime soap is formed. The treatment must be given every time the floor is washed. The floor appears to dry, but it retains surface moisture. If the tile floor is washed with water it will usually be a good insulator in an hour. A tile floor requires treatment each time it is washed. Terrazzo floors may be treated similarly if found not sufficiently conductive and are especially advisable in winter in cold climates. Floors of "magnesite" appear to be highly conductive. This material is being investigated.

Ordinary leather shoes are usually sufficiently conductive if the soles are frequently dampened. When worn outdoors in rainy weather they are highly conductive. In dry weather they may become dangerously nonconductive. Instruments of a simple and relatively inexpensive character have been designed and should be available for testing resistance of shoes and floors. Tests should be made daily, and shoes and floors treated if not found in proper condition.

Conductive rubber which is flexible and resilient has recently been developed by several makers. It should be used for the parts of the anesthesia apparatus but must be tested frequently. As at present available it will retain its conductivity long enough to be most useful and it is not too expensive. However, this rubber deteriorates especially when repeatedly flexed or stretched excessively. Shoe soles made of it are conductive. One pair examined lost its conductivity after four months when purposely abused. Investigations are now in progress looking to improvement of this conductive rubber. Since no other way is known to insure safety of the anesthesia apparatus, this conductive rubber should be adopted at once until a better product is available. Leather shoes may be used pending improvement of the lasting qualities of the conductivity.

All electrical equipment to be used in operating rooms should be of approved design and construction and should be examined and tested at stated intervals to determine its continued fitness. Routine examinations of insulation resistance should be made at frequent intervals.

Motors used in operating rooms to drive bone saws, suction apparatus and ether anesthetic apparatus should be of approved explosion proof design or enclosed in approved explosion proof cases. These should bear a label or plate stating that the device has been passed by proper authority as explosion proof.

Electric outlets should be of such design and construction that plugs cannot be inserted when the current is on nor removed when it is on. All switches should be of approved explosion proof construction, especially foot switches when ether is used.

X-ray equipment to be employed in operating rooms should be especially designed and constructed to eliminate danger of sparks igniting combustible gases or vapors. Existing equipment can sometimes be modified to accomplish this. No woolen or silk outer garments should be worn in operating rooms by any person (including visitors); also no garments of such synthetics as rayon and shark skin. Woolen blankets should not be used. Conductive rubberized cloth should be employed for operating table mattress covers and pillow covers as soon as available. It is available now but should not be adopted in quantity until the question of durability is answered.

Treatment of linen used on operating table and stretchers on which anesthetized patients are moved may be given to increase its electrical leakage. If dipped in 1 per cent calcium chloride solution and then centrifuged in the manner usual in laundries, it dries so that it cannot be distinguished from ordinary linen by touch, but it is much more conductive. It may be desirable to do this in winter, especially in sections where very low winter temperatures prevail. It will probably not be necessary in summer. Care should always be exercised not to place or remove sheets and blankets with unnecessary suddenness of movement from anesthetized patients. It may not be practical to put linen thus treated through a mangle.

The explosion hazard has been distinctly increased by mixing oxygen with ether vapor and with such gases as ethylene and cyclopropane, all of which are distinctly desirable except for the explosion danger.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

OFFICE OF THE COUNCIL.

SUSPENSION OF EPINEPHRINE IN OIL, 1:500-N. N. R.—Suspension of epinephrine base 1:500-N. N. R. A 0.2 per cent suspension, containing 1 part of epinephrine U. S. P. to 500 parts of vegetable oil.

Actions and Uses.—Injections of solutions of epinephrine salts (1:1,000) are known to provide prompt but transient relief in the treatment of severe attacks of bronchial asthma by relaxation of the bronchial muscles. Recent evidence indicates that injections of vegetable oil suspensions of epinephrine base (1:500) delay but prolong the action of the alkaloid and thus provide more sustained symptomatic relief in this condition as well as in certain cases of hay fever, urticaria, angioneurotic edema and serum sickness. The usual contraindications to epinephrine must be kept in mind. The preparation should not be given to the aged or to patients with hypertension, because of its prolonged pressor effects. Its sustained action may also prolong disagreeable side effects as well as serious reactions due to overdosage in less tolerant individuals. Local reactions due to irritation by the oil, especially when injected subcutaneously, have also been reported. For this reason it is recommended that it be administered intramuscularly and that particular attention be paid to the possibility of scar formation (fibrosis) at the sites of injection. Reactions from the epinephrine itself may be partially avoided by adequate resuspension (shaking) of any precipitate in the oil, the use of a dry syringe and needle, and precaution to prevent injecting directly into the blood stream by withdrawal of the syringe plunger to determine the location of the needle point in relation to a vessel before each injection and caution in the selection of the initial dose. The use of a small caliber needle to minimize trauma to blood vessels is also recommended. Intravenous injection is, of course, contraindicated.

Dosage.—Intramuscularly from 0.2 cc. to 1.5 cc. (0.4 mg. to 3.0 mg. epinephrine base) administered every eight to sixteen hours. The initial dose for adults should never exceed 0.5 cc. (1 mg. epinephrine base) and caution is necessary when subsequent doses larger than 1.0 cc. are employed because of the unusually large amount of active material introduced (1 cc. of the oil suspension 1:500 is the equivalent of 2 cc. of an epinephrine solution 1:1,000) and its more prolonged action. Doses in excess of 1.5 cc. are not recommended.

Epinephrine in oil occurs as a pale yellow to white milky suspension from which a white solid settles out on standing. Centrifugate an ampule of epinephrine in oil until the crystals have collected in the bottom, open the ampule, decant the clear oil, and wash the residue with two 1 cc. portions of acetone by decantation: the residue, dried at 75 C., melts above 215 C., when heated at a rate of 8 degrees per minute.

Transfer an accurately measured volume of epinephrine in oil, containing approximately 8 mg. of epinephrine to a centrifuge tube. Centrifuge, wash and dry as described above. Dissolve the residue in 0.40 cc. of normal hydrochloric acid, filter and polarize in a micropolariscope tube. The specific rotation $[\alpha]_D^{25}$ is between —50.0 and —53.5 degrees.

Shake 1.0 cc. of epinephrine in oil with 5.0 cc. of hundredth-normal hydrochloric acid, add 20.0 cc. of distilled water, shake, filter through a paper previously moistened with water. Discard the first 5 cc. and save the remainder for the test. To 20.0 cc. of 1 per cent potassium iodate solution contained in a 50 cc. flask add 0.50 cc. of normal hydrochloric acid, warm to 38 C., and add 10.0 cc. of the filtrate. At the same time, prepare a standard by the method described above, after adding 5.0 cc. of solution containing 8.0 mg. of U. S. P. epinephrine in 20.0 cc. of hundredth-normal hydrochloric acid to 1.0 cc. of peanut oil. Warm the standard and sample solution for fifteen minutes at 38 C., cool to room temperature, and compare in a colorimeter. The epinephrine content is not more than 2.15 nor less than 1.85 mg. per cc.

Epinephrine in Oil, 1:500-Squibb.—A brand of suspension of epinephrine in oil 1:500-N. N. R.

Manufactured by E. R. Squibb & Sons, New York. No U. S. patent or trademark.

Ampules Epinephrine in Oil 1:500-Squibb, 1 cc.: A suspension of 2 mg. powdered epinephrine crystals in 1 cc. of peanut oil.

LIVER EXTRACT U. S. P. ORAL (STEARNS).—An aqueous concentrate of the anti-pernicious anemia factor from fresh, edible mammalian (equine) livers, to which has been added alcohol 18 per cent as a preservative. The daily oral administration of 60 cc. (2 fluidounces) has been found to produce the standard reticulocyte response defined as 1 U. S. P. unit (oral) when assayed in cases of pernicious anemia as required by the Council.

Actions and Uses.—Liver extract U. S. P. oral (Stearns) is used in the treatment of pernicious anemia during relapse and for the maintenance of normal health in patients with pernicious anemia. See general article Liver and Stomach Preparations, New and Nonofficial Remedies, 1940, p. 320.

Dosage.—For the average adult patient in relapse, 1 or more oral units daily. The maintenance dose should not be less than 60 cc. (1 U. S. P. oral unit) daily.

Manufactured by Frederick Stearns & Co., Detroit. No U. S. patent or trademark.

Liver Extract U. S. P. oral (Stearns) is prepared from livers selected from healthy animals, U. S. government inspected, and as free from fat as possible. The livers are finely ground and extracted several times with water. After precipitation of the protein by heat, the volume of liquid is reduced in vacuo at a low temperature, alcohol added to bring the alcoholic strength to 60 per cent, the precipitate filtered out, and the filtrate again evaporated. The residue is dissolved in water, and alcohol is added to give a final extract containing 18 per cent of alcohol by volume.

LIVER EXTRACT-ENDO.—A dried, powdered, nitrogenous fat-free, water soluble extract, prepared from fresh mammalian livers. The daily oral dose of approximately 25 Gm. (fifty capsules) has been found to produce the standard reticulocyte response defined as 1 U. S. P. unit (oral) when assayed in cases of pernicious anemia as required by the Council.

Actions and Uses.—Liver extract-Endo is used in the treatment of pernicious anemia. See the general article Liver and Stomach Preparations, New and Nonofficial Remedies, 1940, p. 320.

Dosage.—Initial dose, fifty capsules (approximately 25 Gm.) daily until examination shows a satisfactory blood cell count. The dosage is then kept at a level which will maintain remission.

Distributed by Endo Products, Inc., Richmond Hill, N. Y. No U. S. patent or trademark.

Liver Extract-Endo, Capsules: Fifty capsules represent 1 oral unit.

Liver extract-Endo is prepared as follows: Fresh edible liver is extracted with water at 170 F. for thirty minutes and filtered. The filtrate is concentrated in vacuo and then dried in vacuo. The dried material is powdered and filled into capsules. Each capsule contains the extract from 10 Gm. of fresh liver.

ANTIPNEUMOCOCCIC SERUM, TYPE II (See New and Nonofficial Remedies, 1940, p. 431).

Mulford Biological Laboratories, Sharp & Dohme, Inc., Philadelphia.

Antipneumococcic Serum Type II, Refined and Concentrated-Mulford.—(See New and Nonofficial Remedies, 1940, p. 432): It is marketed in packages of one ampule-vial containing 20,000 units and packages of one ampule-vial containing 50,000 units accompanied by a vial containing a 1:10 dilution of serum for the sensitivity test.

SULFATHIAZOLE (See THE JOURNAL, Jan. 25, 1941, p. 308).

Sulfathiazole-Parke, Davis.—A brand of sulfathiazole-N. N. R.

Manufactured by Parke, Davis & Co., Detroit. No U. S. patent or trademark.

Tablets Sulfathiazole-Parke, Davis, 0.5 Gm. (7.7 grains).
Tablets Sulfathiazole-Parke, Davis, 0.25 Gm. (3.85 grains).

PHYSIOLOGICAL SOLUTION OF SODIUM CHLORIDE (See New and Nonofficial Remedies, 1940, p. 379).

The following dosage forms have been accepted:

Ampules of Physiological Solution of Sodium Chloride, 10 cc.
Ampules of Physiological Solution of Sodium Chloride, 20 cc.
Prepared by Endo Products, Inc., Richmond Hill, N. Y.

MANDELIC ACID (See New and Nonofficial Remedies, 1940, p. 332).

Mandelic Acid-Gane.—A brand of mandelic acid-N. N. R.
Manufactured by Gane's Chemical Works, Inc., New York (Gane & Ingram, Inc., New York, distributor). No U. S. patent or trademark.

BENZEDRINE SULFATE (See New and Nonofficial Remedies, 1940, p. 233).

The following additional dosage form has been accepted:

Benzedrine Sulfate Tablets, 5 mg.

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SATURDAY, MARCH 22, 1941

"ACUTE PNEUMONITIS" VIRUS

Apparently Weir and Horsfall [1] of the International Health Laboratories, New York, have been able to isolate and identify the specific virus of the disease variously known as "acute pneumonitis," [2] "acute diffuse bronchiolitis" [3] or "capillary pneumonia." Five years ago Bowen [4] described this disease, which he termed "acute influenza pneumonitis." Since then, epidemics have been reported with increasing frequency in a half dozen American states as well as in England and France, from which it is apparent that the disease can assume pandemic proportions. "Acute pneumonitis" is characterized by a remarkably high morbidity and in some institutions or localities over 50 per cent of all persons have contracted the disease. Primarily it is an inflammation of the mucous membranes of the respiratory tract, usually limited to the nose, pharynx and larynx but occasionally extending to the trachea and bronchi and in a few cases to the bronchioles and lungs. Constitutional symptoms are usually in proportion to the extent and intensity of the mucosal inflammation. Patients with the milder form of the disease usually complain of coryza, obstruction of the nose, malaise, frontal headache, weakness, dizziness, muscular pains, sweating and anorexia, with fever lasting on an average for two and a half days.[5] Patients with lung involvement may have fever for from four to eight days. Convalescence is usually rapid, without deaths thus far in uncomplicated cases.

Earlier attempts to determine the etiologic factor of this influenza-like disease were unsuccessful. Routine blood cultures were invariably negative. Bacteriologic studies of nasopharyngeal exudates failed to reveal organisms that could be considered of etiologic significance. Haemophilus influenzae, for example, was never found, and there was a remarkable scarcity of pneumococci. Intranasal instillation of nasopharyngeal secretions into ferrets gave transient toxic symptoms,[6] with failure in attempted passive transfer. Aside from demonstrating the absence of the usual influenza virus, these inoculation tests were inconclusive.

The apparent recent increase in the frequency of this disease and its tendency to become pandemic have rendered it of sufficient importance to warrant vigorous attempts to determine the causative agent. Accordingly, about a year ago Weir and Horsfall attempted to infect all the usual laboratory animals by intranasal instillation of throat washings from clinically typical cases. Among the animals tested were ferrets, mice, guinea pigs, rabbits, monkeys, opossums, skunks, woodchucks, voles, deer mice and Syrian hamsters, all of which proved insusceptible to the presumptive pneumonitis virus. The inoculated animals did not develop symptoms of infection, and at necropsy demonstrable lesions were not found in the respiratory tract.

In the hope of finding a susceptible animal, it was finally decided to try the mongoose, an animal available in abundance in the Caribbean islands but whose importation into the United States is prohibited. By modern methods of transportation and communication, however, it was found feasible to divide the work between the New York laboratory and the British Tuberculosis Research Station at Kingston, Jamaica. Frozen or glycerinated throat washings, filtrates and experimental necropsy material were readily transported back and forth between the two laboratories.

Frozen and vacuum dried throat washings from New York patients or glycerinated filtrates of clinical washings were injected intranasally into mongooses, with control injections of sterile 0.85 per cent sodium chloride solution. The inoculated mongooses were observed for abnormalities in temperature, respiration and appetite and for the presence or absence of diarrhea for ten to twelve days, at the end of which time they were anesthetized, bled by cardiac puncture and killed. Of the 90 mongooses inoculated with the first series of four throat washings, 64 per cent developed pulmonary lesions, one third of them showing generalized deep red pulmonary hyperemia without consolidation and two thirds a similar hyperemia surrounding plum colored consolidations. The consolidated areas varied from a single large lesion in one lobe to multiple lesions in several lobes. Examinations of the pulmonary lesions by both microscopic and cultural methods almost invariably showed the lungs to be bacteriologically sterile.

From the infected lungs, however, serial passage was possible to normal mongooses, control tests with emul-

1. Weir, J. M., and Horsfall, F. L.: J. Exper. Med. **72**: 595 (Nov.) 1940.
2. Smiley, D. F.; Showacre, E. D.; Lee, W. F., and Ferris, A. W.: Acute Interstitial Pneumonitis: New Disease Entity, J. A. M. A. **112**: 1901 (May 13) 1939.
3. McKinley, C. A.: Journal-Lancet **59**: 90 (March) 1939.
4. Bowen, A.: Am. J. Roentgenol. **34**: 168 (Aug.) 1935.
5. Reimann, H. A., and Havens, W. P.: Epidemic Disease of Respiratory Tract, Arch. Int. Med. **65**: 138 (Jan.) 1940.
6. Stokes, J., Jr.; Kenney, A. S., and Shaw, D. R.: Tr. & Stud., Coll. Physicians, Philadelphia **6**: 329 (Feb.) 1939.

sions of normal mongoose lungs giving negative results. Filtration tests with both the human nasal washings and emulsions of mongoose lungs showed that the etiologic factor readily passes through the pores of a Berkefeld V or N filter. The virus is readily propagated on the chorioallantoic membrane of the developing chick embryo, thirty serial egg passages having been effected without apparent loss of virulence or specificity.

Normal mongoose serum and serums of infected mongooses during the early stages of the disease failed to demonstrate neutralizing antibodies. Late convalescent mongoose serum, however, is specifically virucidal. Patients with acute pneumonitis also show negative acute phase serums, with neutralizing antibodies appearing only during convalescence. Cross neutralizing tests showed that the newly discovered virus has no antigenic component common with the influenza virus or with any other virus thus far available for cross immunization tests. Viruses from different patients and from different geographic areas were apparently identical qualitatively though slightly different in virulence. Studies of natural methods of infection have shown that the experimental virus disease in the mongoose is readily spread by contact. The evidence therefore seems complete that the mongoose infecting virus is the cause of the current incipient pandemic of acute pneumonitis.

Aside from its epidemiologic importance the work of Weir and Horsfall is noteworthy and may long serve as a model of speed and effectiveness in international medical research, an inspiring example of preparedness for future epidemiologic emergencies.

PHYSICAL FITNESS FROM TWO TO TWENTY

For more than a century countless workers in medical and allied fields have been actively engaged in the study of human growth, development and physical condition. Attention has already been drawn [1] to a series of papers on growth by Wetzel, of Western Reserve University, in Cleveland. This work, and a more extensive analysis [2] published since then, are the foundations for the most recent report by the same investigator on a method for evaluating physical fitness, which appears in this issue of THE JOURNAL.[3] Up to now, by far the greatest advances in the field have pertained to infancy and have formed the basis for the theory and practice of pediatrics. But for the group of persons beyond infancy there has been less formal and less certain guidance, notwithstanding the fact that millions have already been spent on innumerable surveys conducted among preschool, school and college populations. The search for suitable methods of assessing physical fitness has resulted in the proposal of many indexes based on a great variety of body measurements, as well as in an enormous amount of reduplicated effort.

The literature on physical fitness is one of the most voluminous in the entire domain of medicine, as attested by the compilation of 2,500 abstracts made in 1927 at the request of the Children's Bureau.[4] On the question of physical fitness among children the committee in charge expressed the view that "no single factor is of greater importance in dealing with the health of nations." In the past fifteen years, however, it has been realized that large scale surveys have proved to be, if not wholly fruitless, at least much less productive of useful results than had been hoped for. A recent commentator [5] has summarized this situation and has suggested that "research workers concentrate on the construction of valid methods of determining nutritional status rather than making surveys which are of doubtful significance because of the inaccuracies of the estimates upon which their findings are based." Thus the great obstacle to progress in this field has been the lack of a suitable, uniform and practical method for the detection of the physically unfit.

Wetzel has approached the problem from the point of view that physical fitness implies "normal" growth and development, whereas physical unfitness is associated with disturbances of growth and nutrition. His former inquiries into the nature of growth have enabled him to set out a simple graphic chart for following up past, and for predicting future, progress in physical development. In brief, his present contribution seems to provide a simple method for the quick, practical and wholly objective evaluation of the physical condition of any person up to and including maturity. This is of vital importance to more than forty million persons [6] in this country alone who are under 20 years of age. The method, as Wetzel is careful to point out, does not supplant the physician; instead its direct purpose is to aid the physician in judging the nutritional state with greater certainty, rapidity and efficiency than before, since nothing beyond the usual measurements of height, weight and age is required for a rating.

The clue to the new use of heights and weights is undoubtedly to be found in what Wetzel calls the "grid" or "channel system" in which those data are to be plotted. By so doing, one obtains an immediate graphic estimate of physique or body build, development, nutritional grade, physical status, age advancement and maturation. What these attributes have signified in the

1. The Motion of Growth, editorial, J. A. M. A. **103**: 2030 (Dec. 29) 1934; Retarded Growth and Longevity, ibid. **104**: 1826 (May 18) 1935.
2. On the Motion of Growth: XVII. Theoretical Foundations, Growth **1**: 6 (April) 1937.
3. Wetzel, N. C.: Physical Fitness in Terms of Physique, Development and Basal Metabolism, this issue, p. 1187.
4. References on the Physical Growth and Development of the Normal Child, Pub. 179, Children's Bureau, U. S. Dept. of Labor, 1927, iii.
5. Estimates of Nutritional States, editorial, Am. J. Pub. Health **28**: 871 (July) 1938.
6. White House Conference Addresses and Abstracts, New York, Century Company, 1931, p. vii.

past has always been left largely to individual interpretation. Wetzel's approach, however, has resulted for the first time in a unique, precise, yet simple definition of each of these terms. Other factors, such as basal heat production and daily caloric intake, may also be read from the chart for every level between infancy and maturity. Successive heights and weights taken at annual or semiannual intervals establish an invaluable record of progress that may be compared directly with the standards contained in the chart, which themselves offer guidance in the way of prognosis. For example, Wetzel has shown that healthy children tend to develop along given channels "as though these were preferred paths," without undergoing significant alteration in their physique or showing much departure from their own age schedules. "Cross channel progress," on the other hand, indicates either "overnutrition" or "undernutrition," depending on the direction of advance.

While the results cited contribute to the anthropology and genetics of human development and especially to the problem of somatotyping, they are of more immediate concern to the medical examiner. He is now enabled to recognize at a glance whether a child is safely situated in a channel where its nutrition cannot be seriously questioned or whether it belongs to the abnormal groups. The grid, like a screen, is thus intended to separate subjects who are in need of special attention from those whose progress is unsatisfactory. In tests on several thousand Cleveland school children the method has already shown a 94 per cent degree of reliability in picking out the subjects whom experienced examiners call "poorly nourished" or "borderline." Administrators, actuarians and others who carry the great responsibility of directing community and school health work can hardly fail to recognize in the "grid technic" a means of rapidly extracting the vast amount of information which is otherwise buried in existing records and of putting this to good use. The subjectivity of the present day "quick" inspection may well give way to the objective ratings offered by the grid method of analysis. The child who, by methods in current use, is examined but two or three times in his entire school career will be brought up at once, if necessary, and incipient disease will no longer gain a start. The plea of all medicine has been prevention. To this end the grid method is clearly directed. Wetzel's contribution has broken fresh ground in its field; but it has also provided a workable scheme that will recreate interest in existing data and in associated problems, the solution of which should be nearer because the avowed objective of so many undertakings in the past—a reliable method of assessing physical condition—is now at hand.

Workers and all agencies of child welfare will be able with this technic to check the population for deficiency and to render aid. Not the least of the advantages of this method will be the uniformity with which the situation in one locality may be more truly compared with others. The results of remedial programs will likewise have a uniform basis of comparison, and the effects of organized efforts to deal with local problems will soon distinguish which measures are worth while and which are not. A nation engaged in national defense cannot afford to overlook the sound advice of Francis Galton [7] "to rightly appraise the effects of external conditions upon development." For this task Wetzel's method of appraising physical fitness comes forward at an opportune time.

Current Comment

FREQUENCY OF EXCRETION OF POLIOMYELITIS VIRUS IN HUMAN STOOLS

According to the improved technic recently introduced by Howe and Bodian,[1] of Johns Hopkins University, poliomyelitis virus can be demonstrated in infectious concentration in 70 per cent of the human stools voided during the first five days of the disease. This is nearly three times the frequency demonstrable by classic methods of intracerebral or intraperitoneal inoculation.[2] In the new technic untreated stools are emulsified in a small volume of distilled water and the emulsion frozen in a solid carbon dioxide bath. One cc. of the thawed emulsion is repeatedly introduced into the nostrils of a rhesus monkey, and the mucous membrane gently rubbed with a pipe cleaner. Although such emulsions contain a rich bacterial flora, bacterial infection apparently never takes place. During the recent Baltimore epidemic the Johns Hopkins investigators applied this simplified technic to stool specimens taken from 14 different paralytic patients. Ten were found to contain sufficient poliomyelitis virus to produce typical paralysis and central nervous system lesions in monkeys. The average incubation period after massive intranasal instillation was about two weeks. Cord to cord passage to a second generation monkey was successful in all cases tested. The simplicity and effectiveness of the new technic, which can be applied without recourse to elaborate means for sterilization and concentration of the inoculum, renders it a promising supplement to routine technical methods. In the opinion of the Baltimore investigators, fecal excretion of poliomyelitis virus in 70 per cent of the cases is epidemiologically significant during the first five days of the disease.

7. Galton, F. P.: Inquiries into the Human Faculty and Its Development, London, J. M. Dent & Sons, 1907, p. 28.

1. Howe, H. A., and Bodian, David: Portals of Entry of Poliomyelitis Virus in the Chimpanzee, J. Infect. Dis. **68**: 198 (May-June) 1940.

2. Paul, J. R.; Trask, J. D., and Culotta, C. S.: Poliomyelitis Virus in Sewage, Science **90**: 258 (Sept. 15) 1939. Kramer, S. D.; Gillian, A. G., and Molner, J. G.: Recovery of Virus of Poliomyelitis from Stools of Healthy Contacts in an Institutional Outbreak, Pub. Health Rep. **54**: 1914 (Oct. 27) 1939.

MEDICAL PREPAREDNESS

In this section of The Journal each week will appear official notices by the Committee on Medical Preparedness of the American Medical Association, announcements by the Surgeon Generals of the Army, Navy and Public Health Service, and other governmental agencies dealing with medical preparedness, and such other information and announcements as will be useful to the medical profession.

ARMY RESERVE OFFICERS ORDERED TO ACTIVE DUTY

FOURTH CORPS AREA

The following additional medical reserve officers have been ordered to active duty by the Commanding General, Fourth Corps Area, which comprises the states of Tennessee, North Carolina, South Carolina, Alabama, Georgia, Mississippi, Florida and Louisiana:

ALBRIGHT, Samuel L., 1st Lieut., Belmont, N. C., Fort Benning, Ga.
ANDERSON, Charles A., 1st Lieut., Clinton, S. C., Orlando, Fla.
ANDERSON, Clyde O., 1st Lieut., St. Petersburg, Fla., Fort Benning, Ga.
ANDERSON, William E., 1st Lieut., Dyersburg, Tenn., Fort Benning, Ga.
BARHAM, Berlin F., 1st Lieut., Mayoden, N. C., Camp Stewart, Ga.
BAXLEY, Harry B., Captain, Blakely, Ga., Fort Bragg, N. C.
BAXLEY, Warren C., 1st Lieut., Macon, Ga., Fort Benning, Ga.
BLAND, Charles A., 1st Lieut., Forest City, N. C., Fort Bragg, N. C.
BLUMBERG, Alfred, Major, Oteen, N. C., Camp Shelby, Miss.
BRINT, Douglas L., 1st Lieut., Bolivar, Tenn., Camp Stewart, Ga.
BROWN, Alton G., 1st Lieut., Rock Hill, S. C., Fort Bragg, N. C.
BROWN, Cecil H., 1st Lieut., Jackson, Tenn, Camp Stewart, Ga.
BROWN, William E., 1st Lieut., Summerville, Ga., Orlando, Fla.
BRUNSON, Joseph W., 1st Lieut., Camden, S. C., Fort Benning, Ga.
BUGG, Everett L., Jr., 1st Lieut., Durham, N. C., Fort Bragg, N. C.
BURN, Edward M., 1st Lieut., Charleston, S. C., Fort Jackson, S. C.
BUSSABARGER, Robert A., 1st Lieut., Memphis, Tenn., Fort Benning, Ga.
CARROLL, Bruce D., 1st Lieut., Miami, Fla., Fort Benning, Ga.
CHAMBLEE, John S., 1st Lieut., Windsor, N. C., Fort McClellan, Ala.
CLAVERIE, Eugene H., 1st Lieut., Lafayette, La., Orlando, Fla.
COE, Isaac S., 1st Lieut., Memphis, Tenn., Fort Bragg, N. C.
COFFEY, James C., 1st Lieut., Cliffside, N. C., Camp Stewart, Ga.
ELDRIDGE, Jesse C., Lieut. Col., Chattanooga, Tenn., Knoxville, Tenn.
FAISON, Thomas G., Captain, Winton, N. C., Fort Jackson, S. C.
FULLER, William A., Jr., 1st Lieut., Atlanta, Ga., Fort McPherson, Ga.
GARRISON, Ralph B., 1st Lieut., Hamlet, N. C., Fort Benning, Ga.
HOLLOWELL, Claude V., 1st Lieut., Corapeake, N. C., Fort Bragg, N. C.
HULSEY, John M., Jr., Captain, Gainesville, Ga., Orlando, Fla.
LITTON, James H., 1st Lieut., Milledgeville, Ga., Camp Blanding, Ga.
LLOYD, Preston C., 1st Lieut., Kinston, N. C., Fort Devens, Mass.
MARTIN, David W., 1st Lieut., West Palm Beach, Fla., Fort Benning, Ga.
MARTIN, Marion T., 1st Lieut., Memphis, Tenn., Camp Polk, La.
MASSEY, James L., 1st Lieut., Quincy, Fla., Fort Jackson, S. C.
McCALL, Robert E., Jr., 1st Licut., Marion, N. C., Fort Jackson, S. C.
RAMEY, Daniel R., Jr., 1st Lieut., Holt, Ala., Camp Polk, La.
RAWLS, Jack L., 1st Lieut., Bastrop, La., Fort Bragg, N. C.
ROGERS, Howard M., Captain, St. Petersburg, Fla., Camp Polk, La.
SNELLING, William R., 1st Lieut., Fernandina, Fla., Camp Lee, Va.
STANFIELD, William W., 1st Lieut., Leaksville, N. C., Camp Polk, La.
STEPHENSON, Samuel Logan, Jr., 1st Lieut., Savannah, Tenn., Fort Jackson, S. C.
TAKACY, Theodore L., 1st Lieut., Slater, S. C., Fort Benning, Ga.
TERHUNE, Samuel R., Captain, Birmingham, Ala., Camp Polk, La.
TIPTON, William M., 1st Lieut., Knoxville, Tenn., Camp Shelby, Miss.
WATSON, Walter H., 1st Lieut., Charleston, S. C., Camp Polk, La.
WILSON, Frank E., 1st Lieut., Tarboro, N. C., Camp Forrest, Tenn.
WOODALL, Paul S., Captain, Birmingham, Ala., Orlando, Fla.

Orders Revoked

AKERS, Noel M., 1st Lieut., McIntyre, Ga.
ANDERSON, Clyde O., 1st Lieut., St. Petersburg, Fla.
AUSTIN, Frederick D., Jr., 1st Lieut., Charlotte, N. C.
BARHAM, Berlin F., 1st Lieut., Mayoden, N. C.
BIRD, Donald P., 1st Lieut., Lakeland, Fla.
BOOKER, John P., 1st Lieut., Walhalla, S. C.
BROWN, Ralph E., 1st Lieut., Barnwell, S. C.
BROWN, Randall G., 1st Lieut., Graymont, Ga.
BURNS, Cornelius B., 1st Lieut., New Orleans.
CHASTAIN, Joseph R., 1st Lieut., Buford, Ga.
CLAVERIE, Eugene H., Jr., 1st Lieut., Lafayette, La.
COFFEY, James C., 1st Lieut., Cliffside, N. C.
CRANE, Wesley T., 1st Lieut., Auburn, Ala.
DAWSON, George R., Captain, Charleston, S. C.
FILLINGIM, David B., 1st Lieut., Savannah, Ga.
FOGEL, Julius M., 1st Lieut., Fort Benning, Ga.
FULLER, William A., 1st Lieut., Atlanta, Ga.
GARRISON, Ralph B., 1st Lieut., Hamlet, N. C.
GIBBONS, George E., 1st Lieut., Hampshire, Tenn.
GLENN, Francis W., 1st Lieut., Miami, Fla.
HEWES, Archibald C., 1st Lieut., Gulfport, Miss.
HOLT, Howard P., 1st Lieut., Rodessa, La.
HOWDON, William M., 1st Lieut., Miami, Fla.
HOWELL, Robert S., 1st Lieut., Coral Gables, Fla.
JERNIGAN, Henry C., 1st Lieut., Black Mountain, N. C.
JOYNER, Rayburn N., 1st Lieut., Marianna, Fla.
KING, Ralph E., 1st Lieut., Winnsboro, La.
LAMAR, Carlos P., 1st Lieut., Miami, Fla.
LAMB, Roland D., 1st Lieut., Columbus, Miss.
LANCE, Vernal L., 1st Lieut., Blairsville, Ga.
MARTIN, David W., 1st Lieut., West Palm Beach, Fla.
MARTIN, Robert B., III, 1st Lieut., Shellman, Ga.
MICKAL, Abe, 1st Lieut., New Orleans.
MILLER, Cecil E., 1st Lieut., Sarasota, Fla.
MOULEDOUS, Shelley J., 1st Lieut., Abbeville, La.
PHILLIPS, Stonewall J., Captain, Oakdale, La.
ROGERS, Hunter B., Captain, Miami, Fla.
SPRUELL, William H., 1st Lieut., Russellville, Ala.
TAKACY, Theodore L., 1st Lieut., Slater, S. C.
TAYLOR, Guy F., 1st Lieut., Laurel Springs, N. C.
VAUDRY, James W., 1st Lieut., New Orleans.
WAGNER, Rudolph T., 1st Lieut., Miami Beach, Fla.
WILSON, Richard A., 1st Lieut., Wilmington, N. C.

SIXTH CORPS AREA

The following additional medical reserve officers have been ordered to extended active duty by the Commanding General, Sixth Corps Area, which comprises the states of Wisconsin, Illinois and Michigan:

ADLER, Samuel, 1st Lieut., Oregon, Ill., Replacement Center, Camp Grant, Ill.
ALTMAN, Harris P., 1st Lieut., Marengo, Ill., Station Hospital, Fort Bliss, Texas.
BACKER, Meyer, 1st Lieut., Chicago, Station Hospital, Fort Sill, Okla.
BAILIS, Jack M., 1st Lieut., Pittsfield, Ill., 2d Med. Lab., Fort Sam Houston, Texas.
BAKER, Alonzo N., 1st Lieut., Marion, Ill., 30th Division, Fort Jackson, S. C.
BALLIN, Michael, 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
BALLOU, John W., 1st Lieut., Rushville, Ill., Station Hospital, Fort Bliss, Texas.
BARBER, Kent W., 1st Lieut., Quincy, Ill., Station Hospital, Fort Bliss, Texas.
BARD, Eli, 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
BARNETT, Andrew F., 1st Lieut., West Frankfort, Ill., Station Hospital, Fort Bliss, Texas.
BERARDI, James B., 1st Lieut., Dwight, Ill., Station Hospital, Fort Sam Houston, Texas.
BIELINSKI, Brunon, 1st Lieut., Manteno, Ill., Station Hospital, Fort Sam Houston, Texas.
BITTER, Reuben, Captain, Oshkosh, Wis., 12th Cavalry, Fort Brown, Texas.
BLADES, James E., 1st Lieut., Sidney, Ill., 4th Medical Supply Depot, Fort Sam Houston.
BOLLES, Carlton S., 1st Lieut., DePere, Wis., Station Hospital, Fort Sam Houston, Texas.
BOYER, Richard C., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
BOYNTON, Melbourne W., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
BRAZE, Alexander, Captain, Rockford, Ill., Station Hospital, Camp Grant, Ill.
BROWN, David Joseph, 1st Lieut., Manteno, Ill., Station Hospital, Fort Sill, Okla.
BROWN, Wilbert O., 1st Lieut., Chicago, Station Hospital, Fort Sill, Okla.
BUCHHOLZ, Alexander M., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
BURLEY, Robert D., 1st Lieut, Beardstown, Ill., Station Hospital, Fort Bliss, Texas.
BUSHNELL, Lowell F., 1st Lieut., Highland Park, Ill., Station Hospital, Fort Sheridan, Ill.
BUTT, Arthur J., Jr., 1st Lieut., Chicago, 30th Division, Fort Jackson, S. C.

CARLIN, George W., 1st Lieut., Wilmington, Ill., Station Hospital, Fort Sill, Okla.
CARTER, Kenneth L., 1st Lieut., St. Louis, Station Hospital, Fort Bliss, Texas.
CARY, John F., 1st Lieut., Sheboygan, Wis., 1st Medical Squadron, Fort Bliss, Texas.
CHABNER, Louis, 1st Lieut., Shelbyville, Ill., Station Hospital, Fort Sam Houston, Texas.
CHYNOWETH, William R., Major, Battle Creek, Mich., Station Hospital, Fort Sam Houston, Texas.
COHEN, Jacob, 1st Lieut., Granite City, Ill., 27th Division, Fort McClellan, Ala.
COHLER, Bernard E., 1st Lieut., Chicago, 30th Division, Fort Jackson, S. C.
COHRS, Clarence C., 1st Lieut., Harvey, Ill., Station Hospital, Fort Sam Houston, Texas.
COLLINS, Harold J., 1st Lieut., LaHarpe, Ill., Replacement Center, Camp Grant, Ill.
CROTTY, John P., 1st Lieut., East St. Louis, Ill., 30th Division, Fort Jackson, S. C.
CZERWINSKI, Anthony, Captain, Springfield, Ill., 107 Obs. Squadron, Camp Beauregard, La.
DAVIS, John L., 1st Lieut., Quincy, Ill., Station Hospital, Fort Sill, Okla.
DeFRANCOIS, Walter, 1st Lieut., Oak Park, Ill., Station Hospital, Fort Sill, Okla.
DeJONGH, Edwin, 1st Lieut., Detroit, 12th Cavalry, Fort Bliss, Texas.
DEW, W. A., Lieut. Col., Belleville, Ill., Station Hospital, Fort Sill, Okla.
DEWHIRST, Ernest M., Captain, Danville, Ill., Station Hospital, Camp Grant, Ill.
DICKERSON, Donald L., 1st Lieut., Danville, Ill., Station Hospital, Fort Bliss, Texas.
DICKEY, Marvin M., 1st Lieut., Richmond, Ill., Station Hospital, Fort Sill, Okla.
DIETRICH, Edwin, 1st Lieut., Fithian, Ill., Station Hospital, Fort Bliss, Texas.
DOBIN, Norman B., 1st Lieut., Chicago, Station Hospital, Fort Sill, Okla.
DUBIEL, Charles R., 1st Lieut., Chicago, 27th Division, Fort McClellan, Ala.
EASLEY, John H., 1st Lieut., Wayne, Mich., Replacement Center, Camp Grant, Ill.
FEIN, Harry S., 1st Lieut., Chicago, Fitzsimons General Hospital, Denver.
FEINHANDLER, Harold S., 1st Lieut., Chicago, Station Hospital, Fort Custer, Mich.
FISHER, Robert E., 1st Lieut., Mayville, Mich., 38th Infantry, Fort Sam Houston, Texas.
FORD, Walter A., Lieut. Col., Sheboygan, Wis., Station Hospital, Fort Sill, Okla.
FORTNER, Roscoe J., Captain, Three Rivers, Mich., 30th Division, Fort Jackson, S. C.
FRIEDMAN, Isadore E., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
GAFF, John H., Lieut. Col., Chicago, Station Hospital, Fort Sam Houston, Texas.
GOFF, Marcellus H., Captain, Chicago, 366th Infantry, Fort Devens, Mass.
GOLDSTEIN, Robert M., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
GOODMAN, Louis, 1st Lieut., Monroe, Mich., Station Hospital, Fort Sam Houston, Texas.
GORELICK, Martin J., 1st Lieut., Dearborn, Mich., Station Hospital, Fort Sill, Okla.
GOURLEY, Eugene V., 1st Lieut., Detroit, Station Hospital, Fort Sill, Okla.
GRAHAM, Charles M., 1st Lieut., Altona, Ill., 27th Division, Fort McClellan, Ala.
GUELDNER, Louis H., 1st Lieut., Fort Atkinson, Wis., Station Hospital, Fort Sill, Okla.
GUTOV, Benjamin R., 1st Lieut., Detroit, 27th Division, Fort McClellan, Ala.
HAEREM, Alf T., 1st Lieut., Chicago, Station Hospital, Fort Sill, Okla.
HALPERIN, Isadore, 1st Lieut., Chicago, 27th Division, Fort McClellan, Ala.
HARTFORD, William S., Lieut. Col., Champaign, Ill., Station Hospital, Fort Sam Houston, Texas.
HEIDENREICH, John R., 1st Lieut., Daggett, Mich., Station Hospital, Fort Sam Houston, Texas.
HIRSCH, Donald A., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
HOFFENBERG, Nathan L., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
HOHMAN, Roy Max, 1st Lieut., Chicago, 27th Division, Fort McClellan, Ala.
JACOBS, Maurice B., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
JAMES, William D., 1st Lieut., Oconomowoc, Wis., Station Hospital, Fort Sill, Okla.
KINZEL, Robert J., 1st Lieut., Litchfield, Mich., Station Hospital, Fort Sill, Okla.
KNAUS, William E., 1st Lieut., East St. Louis, Ill., 30th Division, Fort Jackson, S. C.
KOVACH, Emery P., 1st Lieut., Detroit, 30th Division, Fort Jackson, S. C.
KWINN, Frank C., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
LeFEVRE, George L., Major, North Muskegon, Mich., Station Hospital, Camp McCoy, Sparta, Wis.
LERNER, Louis S., Captain, Chicago, Medical Supply Depot, Fort Sam Houston, Texas.
LINN, Herman J., 1st Lieut., Chicago, Station Hospital, Fort Custer, Mich.
LOWELL, Vivion F., 1st Lieut., Ypsilanti, Mich., 30th Division, Fort Jackson, S. C.
MARCHMONT-ROBINSON, Harry, 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
MARTIN, Robert E., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
MATEJKA, James J., 1st Lieut., Chicago, 94th Engineer Battalion, Fort Custer, Mich.
McBAIN, Louis B., Captain, Appleton, Wis., 30th Division, Fort Jackson, S. C.
McCAULEY, Maurice D., 1st Lieut., Detroit, Station Hospital, Fort Sam Houston, Texas.
MILLER, Donald S., 1st Lieut., Chicago, Station Hospital, Fort Custer, Mich.
MOLAND, Oscar G., 1st Lieut., Augusta, Wis., Station Hospital, Fort Sam Houston, Texas.
MONTGOMERY, Alvin Samuel, 1st Lieut., LaCrosse, Wis., Station Hospital, Fort Sam Houston, Texas.
MOORE, Donald F., 1st Lieut., Ypsilanti, Mich., Station Hospital, Fort Sam Houston, Texas.
MORTON, David G., 1st Lieut., Detroit, Station Hospital, Fort Sam Houston, Texas.
MUNSLOW, Ralph A., 1st Lieut., Detroit, Station Hospital Fort Sam Houston, Texas.
MURFIN, Maurice D., 1st Lieut., Decatur, Ill., Station Hospital, Fort Sam Houston, Texas.
MURPHY, Thomas J., 1st Lieut., Decatur, Ill., Station Hospital, Fort Sam Houston, Texas.
MURRAY, Charles A., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
NELSON, Lorenzo R., 1st Lieut., Chicago, 366th Infantry, Fort Devens, Mass.
NELSON, Tell, Captain, Chicago, Station Hospital, Fort Sill, Okla.
NIEDER, Samuel, 1st Lieut., Gilman, Ill., Station Hospital, Fort Sam Houston, Texas.
O'DONNELL, Steven P., 1st Lieut., Kiel, Wis., Station Hospital, Fort Sill, Okla.
PAGEL, H. F., 1st Lieut., Ladysmith, Wis., Station Hospital, Fort Sill, Okla.
PEARSON, John B., 1st Lieut., Mayville, Wis., Station Hospital, Fort Sam Houston, Texas.
PELTZER, Wesley E., 1st Lieut., Oak Park, Ill., 30th Division, Fort Jackson, S. C.
PICKETT, William J., Lieut. Col., Chicago, Station Hospital, Fort Sam Houston, Texas.
POWER, Frank H., 1st Lieut., Ann Arbor, Mich., 30th Division, Fort Jackson, S. C.
PRICE, Harold, 1st Lieut., Chicago, Station Hospital, Fort Custer, Mich.
PSOULOS, George D., Captain, Chicago, Station Hospital, Fort Custer, Mich.
RAU, Gerald A., 1st Lieut., Two Rivers, Wis., Station Hospital, Fort Sam Houston, Texas.
REED, Harry, Captain, Detroit, 94th Engineer Battalion, Fort Custer, Mich.
RESKE, Alven A., 1st Lieut., Dearborn, Mich., Station Hospital, Fort Sam Houston, Texas.
RESTARSKI, Alvin F., 1st Lieut., Chicago, Fifth Division, Fort Custer, Mich.
ROBIN, Milton, 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
ROKITA, Adam W., 1st Lieut., Barry, Ill., Station Hospital, Fort Sam Houston, Texas.
ROSENBERG, Samuel W., 1st Lieut., Milwaukee, Station Hospital, Fort Sam Houston, Texas.
SARMA, Pashupati J., Lieut. Col., Chicago, Station Hospital Fort Sam Houston, Texas.
SAWYER, Preston W., 1st Lieut., Fairmount, Ill., Station Hospital, Fort Sam Houston, Texas.
SCHACH, Arthur C., 1st Lieut., Rockford, Ill., Station Hospital, Fort Bliss, Texas.
SCHROTH, George J., 1st Lieut., Chicago, Station Hospital, Fort Sam Houston, Texas.
SEID, Benjamin, 1st Lieut., Chicago, Station Hospital, Fort Sill, Okla.
SEIFERT, Edward H., Lieut. Col., Galesburg, Ill., Station Hospital, Fort Bliss, Texas.
SHAPIRO, Louis B., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.
SIMPSON, Reed M., 1st Lieut., Hardin, Ill., Station Hospital, Fort Sill, Okla.
SLOAN, Fred R., 1st Lieut., Wauwatosa, Wis., Station Hospital, Fort Sam Houston, Texas.
SLUSSER, Gerald A., 1st Lieut., Villa Grove, Ill., Station Hospital, Fort Bliss, Texas.
SPECTOR, Maurice J., 1st Lieut., Detroit, Station Hospital, Fort Sill, Okla.
SULLIVAN, James M., 1st Lieut., Milwaukee, Station Hospital, Fort Sam Houston, Texas.
TEASLEY, Benager C., 1st Lieut., Robinson, Ill., Station Hospital, Fort Sill, Okla.
TERWILLIGER, Edwin, 1st Lieut., South Haven, Mich., Station Hospital, Fort Sam Houston, Texas.
TOUSIGNANT, Albert N., Captain, Oconto, Wis., Station Hospital, Fort Sill, Okla.
TROTTER, Jay D., 1st Lieut., Carthage, Ill., Station Hospital, Fort Sill.
WILSON, Clyde S., Lieut. Col., Belleville, Ill., Station Hospital, Camp Grant, Ill.
WINER, Allen E., 1st Lieut., Chicago, Station Hospital, Fort Bliss, Texas.

SEVENTH CORPS AREA

The following additional medical reserve officers have been ordered to extended active duty by the Commanding General, Seventh Corps Area, which comprises the states of North Dakota, South Dakota, Minnesota, Nebraska, Iowa, Kansas, Missouri, Arkansas and Wyoming.

ALDRICH, Herrick John, 1st Lieut., Sheridan, Wyo., William Beaumont General Hospital, El Paso, Texas.
ALMER, Lennart Emmanuel, 1st Lieut., Moorhead, Iowa, Fort Knox, Ky.
ANDERSEN, Elmer John Tiemeyer, 1st Lieut., Montgomery City, Mo., Fort Francis E. Warren, Wyo.
BEBER, Meyer, Captain, Omaha, Fort Leonard Wood, Mo.
BENESH, Louis Alfred, 1st Lieut., Minneapolis, Fort Francis E. Warren, Wyo.
BENJAMIN, Harold Garner, 1st Lieut., Minneapolis, Fort Knox, Ky.
BOILER, William F., Major, Iowa City, Fort Leonard Wood, Mo.
BRICKER, Eugene Myron, 1st Lieut., Columbia, Mo., Fort Leonard Wood, Mo.
CHRISTIANSEN, Charles Clifford, Dixon, Iowa, 1st Lieut., Fort Francis E. Warren, Wyo.
COHEN, Harold David, Lieut. Col., Des Moines, Iowa, Fort Leavenworth, Kan.
DRIVER, Donn Raymond, 1st Lieut., Bismarck, N. D., Fort Riley, Kan.
EGGLESTON, Donald Edwin, 1st Lieut., Kingman, Kan., Camp Murray, Wash.
FLESCHE, Bernard Alton, 1st Lieut., Lake City, Minn., William Beaumont General Hospital, El Paso, Texas.
FLYNN, Joseph Eugene, 1st Lieut., Iowa City, Army and Navy General Hospital, Hot Springs, Ark.
FRIEDMAN, Burt, 1st Lieut., St. Louis, Fort Ord, Calif.
GRIMM, Benjamin Hayes, 1st Lieut., Sidney, Neb., Fort Riley, Kan.
HAMILTON, Benjamin Charles, Major, Jefferson, Iowa, Camp Murray, Wash.
HAYMOND, Harold Everest, Captain, Perry, Iowa, Fort Meade, S. D.
HOLLAND, Frank Flynn, 1st Lieut., St. Joseph, Mo., Fort Leavenworth, Kan.
HOSKINS, James Howard, Major, Wahpeton, N. D., Fort Leonard Wood, Mo.
IVERS, George Urben, 1st Lieut., Fargo, N. D., Fort Leonard Wood, Mo.
JANSONIUS, John Willard, 1st Lieut., Eldora, Iowa, Fort Knox, Ky.
JOFFE, Harold Herman, 1st Lieut., Duluth, Minn., Fort Riley, Kan.
KATZOVITZ, Hyman, 1st Lieut., St. Paul, Fort Francis E. Warren, Wyo.
KING, Richard Sidney, 1st Lieut., Cass Lake, Minn., Fort Francis E. Warren, Wyo.
KITCHEN, William Meyer, 1st Lieut., Moberly, Mo., William Beaumont General Hospital, El Paso, Texas.
KLINGNER, George Malcolm, 1st Lieut., Springfield, Mo., Fort Francis E. Warren, Wyo.
KRAUSE, Richard Alfred, 1st Lieut., West Point, Neb., Fort Riley, Kan.
LEIFER, William Warren, 1st Lieut., Kansas City, Mo., Fort Leonard Wood, Mo.
LEVERENZ, Carleton Walter, 1st Lieut., St. Paul, Fort Francis E. Warren, Wyo.
LIEBERMAN, B. Albert, Jr., Captain, Kansas City, Mo., Fort Leonard Wood, Mo.
LINDGREN, Russell Cyrus, 1st Lieut., Minneapolis, Army & Navy General Hospital, Hot Springs, Ark.
LUPPENS, Albert Franklin, Captain, Kansas City, Mo., Fort Leonard Wood, Mo.
MANGIAMELI, Carl L., 1st Lieut., Omaha, Fort Leonard Wood, Mo.
MARKER, John Israel, Lieut. Col., Davenport, Iowa, Fitzsimons General Hospital, Denver.
McADAM, Charles Rush, 1st Lieut., St. Louis, Fort Leonard Wood, Mo.
McCLAIN, Monroe Dixon, 1st Lieut., Little Rock, Ark., Camp Joseph T. Robinson, Ark.
MORROW, James Joseph, Major, Austin, Minn., Fort Leavenworth, Kan.
NEAS, Ingall Howard, 1st Lieut., Kansas City, Kan., Fort Leonard Wood, Mo.
PUDLEINER, Harold Grant, 1st Lieut., Canton, Mo., Fort Riley, Kan.
REAGAN, Charles Henry, Captain, Marked Tree, Ark., Fort Bliss, Texas.
RETTENMAIER, Albert Joseph, 1st Lieut., Kansas City, Kan., Fort Francis E. Warren, Wyo.
ROGERS, Earl Elvin, 1st Lieut., Lincoln, Neb., Fort Leonard Wood, Mo.
RUSH, Weaver Aldus, Major, Beatrice, Neb., Fort Leonard Wood, Mo.
SCHWYZER, Hanns Carl, 1st Lieut., St. Paul, Fort Leonard Wood, Mo.
SILSBY, Harry Dozier, 1st Lieut., Springfield, Mo., Fort Ord, Calif.
SINCLAIR, Richard Clyde, 1st Lieut., St. Louis, Fort Ord, Calif.
SPIELHAGEN, Guenther F., 1st Lieut., Iowa City, Jefferson Barracks, Mo.
SQUIBB, Joseph William, 1st Lieut., Springfield, Mo., Fort Francis E. Warren, Wyo.
WAKEMAN, Don Conklin, 1st Lieut., Topeka, Kan., Fort Leonard Wood, Mo.
WANNER, Jay George, Captain, Rock Springs, Wyo., Fort Francis E. Warren, Wyo.
WHITE, Charles Herbert, 1st Lieut., Kansas City, Mo., Fort Leonard Wood, Mo.

Orders Revoked

COHEN, Harold David, Lieut. Col., Des Moines, Iowa, Fort Leavenworth, Kan.
GLAZE, Kenneth Franklin, 1st Lieut., St. Louis, Fort Lewis, Wash.
HAGEBUSCH, Omer Ernst, 1st Lieut., University City, Mo., William Beaumont General Hospital, El Paso, Texas.
HAWKINSON, Raymond Paul, Captain, Robbinsdale, Minn., Fort Des Moines, Iowa.
HENDERSON, Richard Gray, 1st Lieut., St. Louis, William Beaumont General Hospital, El Paso, Texas.
LEVIN, Abraham Jacob, 1st Lieut., St. Louis, Fort Lewis, Wash.
SINCLAIR, Richard Clyde, 1st Lieut., St. Louis, Fort Ord, Calif.

EIGHTH CORPS AREA

The following additional medical reserve corps officers have been ordered to active duty by the Commanding General, Eighth Corps Area, which comprises the states of Colorado, Arizona, New Mexico, Oklahoma and Texas:

AKINS, Jack Odie, 1st Lieut., Tulsa, Okla., Fort Sam Houston, Texas.
ALLEN, George Scott, 1st Lieut., Burnet, Texas, Fort Bliss, Texas, Station Hospital.
ANDERSON, Robert E., 1st Lieut., Woodmen, Colo., Fort Bliss, Texas.
ANTHONY, William Dodd, 1st Lieut., Gallup, N. M., 25th Infantry, Fort Huachuca, Ariz.
BARTHELD, Floyd T., 1st Lieut., McAlester, Okla., Camp Bowie, Texas.
BATE, Thomas H., 1st Lieut., Phoenix, Ariz., Station Hospital, Fort Bliss, Texas.
BECK, Harold J., 1st Lieut., Jersey City, N. J., Station Hospital, Fort Sam Houston, Texas.
BERGENER, Karl L., 1st Lieut., Tulsa, Okla., 25th Infantry, Fort Huachuca, Ariz.
BICKEL, Robert David, 1st Lieut., Gallup, N. Mex., Fort Bliss, Texas, Station Hospital.
BLAIR, William M., 1st Lieut., Wharton, Texas, Camp Bowie, Texas.
BROWN, Jesse Benjamin, 1st Lieut., Belton, Texas, Camp Barkley, Texas.
BUNKLEY, Thomas A., 1st Lieut., Stamford, Texas, 25th Infantry, Fort Huachuca, Ariz.
BURGESS, George, 1st Lieut., Dallas, Texas, Camp Bowie, Texas.
CALONGE, Guy E., 1st Lieut., La Junta, Colo., Station Hospital, Fort Bliss, Texas.
CARSON, John M., 1st Lieut., Shawnee, Okla., 36th Division, Camp Bowie, Texas.
CASH, Aeneas Peter, 1st Lieut., La Junta, Colo., Camp Barkley, Texas.
COCHRAN, John Robert, 1st Lieut., Fort Worth, Texas, San Angelo, Texas, Basic Flying School.
CONDELL, Lyle A., 1st Lieut., Safford, Ariz., 25th Infantry, Fort Huachuca, Ariz.
CRAWFORD, John M., Captain, Carrizo Springs, Texas, 36th Division, Camp Bowie, Texas.
CURRY, John Russell, 1st Lieut., Blackwell, Okla., Camp Barkley, Texas.
DANIELL, Alfred H., 1st Lieut., Brownfield, Texas, San Angelo, Texas, Basic Flying School.
DIVINE, James B., 1st Lieut., Graham, Texas, 25th Infantry, Fort Huachuca, Ariz.
EDENS, Clarence, 1st Lieut., San Antonio, Texas, Camp Bowie, Texas.
EVANS, Alfred, 1st Lieut., Perry, Okla., Camp Barkley, Texas.
FORTNEY, Paul N., 1st Lieut., Beaumont, Texas, Fort Bliss, Texas, Station Hospital.
FRANK, Charles H., Captain, Texarkana, Texas, Station Hospital, Fort Sill, Okla.
GOETH, Carl F., 1st Lieut., San Antonio, Texas, Camp Bowie, Texas.
GOSSETT, Robert Francis, 1st Lieut., San Antonio, Texas, Fort Bliss, Texas, Station Hospital.
GRAMMER, James Henry, 1st Lieut., Fort Worth, Texas, Camp Barkley, Texas.
GRAY, Paul Milton, 1st Lieut., Corpus Christi, Texas, Lowry Field, Colo.
GUTHRIE, Aubrey E., 1st Lieut., Ploydada, Texas, 349th Field Artillery, Fort Sill, Okla.
HARTWICK, Fred Walter, 1st Lieut., Victoria, Texas, San Angelo, Texas, Basic Flying School.
HENDERSON, Walter T., 1st Lieut., Dallas, Texas, 36th Division, Camp Bowie, Texas.
HEWATT, John W., Captain, Fort Worth, Texas, Lowry Field, Colo.
HULSEY, Simeon H., Captain, Fort Worth, Texas, Station Hospital, Sam Houston, Texas.
HYDER, Prentiss L., 1st Lieut., Corpus Christi, Texas, 36 Division, Camp Bowie, Texas.
JOHNSTON, Leonidas A. S., 1st Lieut., Holdenville, Okla., Station Hospital, Fort Sam Houston, Texas.
JONES, Edmund Dennis, Captain, Beaumont, Texas, 20th Coast Artillery, Fort Crockett, Texas.
KATZ, Solomon M., 1st Lieut., Dallas, Texas, Camp Barkley, Texas.
KENT, Melvin Lloyd, 1st Lieut., Mesa, Ariz., Station Hospital, Fort Sill, Okla.
KILMAN, P. T., Captain, Malakoff, Texas, Camp Bowie, Texas.
KING, Thomas C., 1st Lieut., Electra, Texas, Station Hospital, Fort Sam Houston, Texas.
KUPKA, John F., 1st Lieut., Haskell, Okla., Camp Barkley, Texas.
LAWRENCE, Buell A., 1st Lieut., Houston, Texas, Station Hospital, Fort Sill, Okla.
LIPSCOMB, Cuvier P., 1st Lieut., Denison, Texas, Lowry Field, Colo.
MAGLIOLO, Andrew J., Jr., 1st Lieut., Galveston, Texas, Fort Sam Houston, Texas.
MAGNESS, William H., Captain, Denton, Texas, 45th Division, Camp Barkley, Texas.
MARCHMAN, Oscar M., Jr., 1st Lieut., Longview, Texas, Kelly Field, Texas.
MARSHALL, Reagan M., 1st Lieut., Houston, Texas, Lowry Field, Colo.
MARTIN, Claud A., 1st Lieut., Austin, Texas, Camp Barkley, Texas.
McCLURE, Harold M., 1st Lieut., Chickasha, Okla., Camp Barkley, Texas.

McMULLEN, James Wallace, Major, Denver, Colo., Fort Bliss, Texas, Station Hospital.
McVEIGH, Joseph Fielding, Captain, Fort Worth, Texas, Fort Sam Houston, Texas, Station Hospital.
MILBURN, Kennedy A., Captain, San Antonio, Texas, Lowry Field, Colo.
MILLER, John Burr, Jr., 1st Lieut., San Antonio, Texas, Camp Bowie, Texas.
NEWLIN, William H., 1st Lieut., Sallisaw, Okla., Camp Barkley, Texas.
OATES, L. S., 1st Lieut., Center, Texas, Station Hospital, Fort Sill, Okla.
OXMAN, Bertram Sidney, 1st Lieut., Wetumka, Okla., Fort Bliss, Texas.

Orders Revoked

APPEL, Myron Henry, 1st Lieut., Alice, Texas.
BAZE, Roy Ellis, 1st Lieut., Chickasha, Okla.
BLAIR, William M., 1st Lieut., Wharton, Texas.
CASH, Aeneas Peter, 1st Lieut., La Junta, Colo.
CAUSEY, Paul Spencer, 1st Lieut., Douglas, Ariz.
COWART, O. H., 1st Lieut., Bristow, Okla.
ETTER, Edward F., Captain, Sherman, Texas.
GALLAHER, Paul C., 1st Lieut., Shawnee, Okla.
GARCIA, Robert E., 1st Lieut., Parker, Ariz.
GOSSETT, Robert Francis, 1st Lieut., San Antonio, Texas.
HAMPTON, Dan E., 1st Lieut., Denver.
HAMRA, Henry, M., 1st Lieut., Phillips, Texas.
HERNDON, James H., 1st Lieut., Dallas, Texas.
JERMSTAD, Robert J., 1st Lieut., Fort Worth, Texas.
KING, Everett G., 1st Lieut., Duncan, Okla.
McCLURE, Harold M., 1st Lieut., Chickasha, Okla.
MILLER, Hubert Wainwright, 1st Lieut., Artesia, N. Mex.
NEWMAN, M. H., 1st Lieut., Shattuck, Okla.
SHERE, Norbert L., 1st Lieut., Denver.
SHUPE, Reed Dalton, Captain, Phoenix, Ariz.
WATERS, Floyd Leo, 1st Lieut., Hugo, Okla.
WHEELER, Norman O., 1st Lieut., Globe, Ariz.
WOODALL, John B., 1st Lieut., Kerrville, Texas.
WOODARD, Thad L., 1st Lieut., Dallas, Texas.

SURGICAL HOSPITALS IN THE FIELD

Three surgical hospitals for use in the field are to be activated in June: the 61st Surgical Hospital, Fort Meade, Md., the 63d Surgical Hospital, Fort Oglethorpe, Ga., and the 74th Surgical Hospital, Fort Warren, Wyo. The Army Medical Corps is now carefully studying two types of surgical hospitals at the Medical Field Service School, Carlisle Barracks, Pa. Consideration is now being given to housing surgical hospitals in bus-type ambulances, each of which will operate its own power unit. Originally these hospitals were designed to be housed in trailers. The ambulance types, however, are said to have several advantages, as they can be built closer to the ground and, by having their own power unit, will be able to leave a dangerous zone quickly. All the foregoing three surgical hospitals will be training units, each with three officers and one hundred and ten enlisted men, most of whom will be given a thirteen weeks basic training course at the replacement centers at either Camp Lee, Va., or Camp Grant, Ill., before being sent into further unit training in operation of the surgical hospitals. These hospitals are to be completely equipped with every facility found in base hospitals.

APPOINTMENT IN RESERVE CORPS OF GRADUATES OF APPROVED SCHOOLS

The War Department announced, February 18, that Corps Area commanders are authorized to waive the requirements for recommendation of an examining board contained in the third column of paragraph 19 b (8) AR 140-5, and so much of paragraph 20 c of the same regulation as requires reference of application to examining boards, in the case of applicants for appointment in the Medical Corps Reserve from American schools approved by the Council on Medical Education and Hospitals of the American Medical Association, at the time of successful completion of the required four year course of medical instruction, whether the degree of doctor of medicine is conferred at that time or withheld until after an additional period of practical experience. Recommendations under this authority for the appointment in the Medical Corps Reserve of prospective graduates of approved medical schools will be made on a special form which will be forwarded by the adjutant general's office and must be signed by the president or dean of the institution and by the corps area surgeon. Application should not be submitted unless appointment is desired by the prospective graduate, and it appears probable that he will when graduated be eligible and qualified professionally and physically. The papers should be carefully checked to insure that they are completely and correctly prepared. Recommendation sheets and W. D., A. G. O. form numbers 170 and 63 should be assembled for each applicant and all papers for graduates of the same institution should be forwarded to this office under one cover on or before April 15, accompanied by a list of those recommended for appointment, arranged alphabetically. It is essential that every effort practicable be made to avoid delay in submitting recommendations and applications. Applications for appointment in the Medical Corps Reserve from prospective graduates of approved schools at universities or colleges where R. O. T. C. training for other arms and services is conducted should be forwarded separately from applications from prospective R. O. T. C. graduates.

NEW YORK INDUCTION BOARDS PASS 76 PER CENT FOR MILITARY SERVICE

More than 76 per cent of the men examined by physicians of the local induction boards in New York City during three induction periods were found physically fit for military service, according to a report by Col. Samuel J. Kopetzky, chief of the medical division of Selective Service for the city.

Of 17,540 men examined, 13,422 were qualified for full or limited military service. There were 9,925, or 56.6 per cent, available for full service and 3,497, or 19.93 per cent, classified as available for limited service.

The report showed that of the 9,925 passed by the local boards 8,883 were finally accepted by the Army for service. Of the 1,042 rejected when they reached Army induction stations 487 were classified as qualified for limited service and the remaining 555 as unqualified for any service. The study noted two important differences in procedure by the local physicians and those of the Army: local boards are not able to make a roentgenogram of every chest nor are the neuropsychiatric examinations as extensive as they are at the induction stations. Some men were temporarily deferred because they were suffering from transient illnesses but were or will be subsequently inducted.

Defects of teeth or vision led all other reasons for rejection. There were 1,995, or 11.37 per cent, rejections for defects of teeth and gums, while deficient vision accounted for 1,959, or 11.7 per cent. The third largest category was diseases of the heart or blood vessels, 10.75 per cent of all disqualifications.

In addition to the three principal causes for rejection, there were fifteen other groups of defects prevalent in the following order: extremities 7.94 per cent, abdominal organs and wall 5.63 per cent, mental and nervous disorders 4.24 per cent, height-weight 3.97 per cent, ears 3.75 per cent, genitourinary organs and venereal diseases 3.60 per cent, lungs and chest wall 2.70 per cent, mouth, nose and throat 1.67 per cent, spinal 1.39 per cent, endocrine and metabolic disorders 1.39 per cent, skin 0.41 per cent, general and miscellaneous 0.29 per cent, diseases of blood and blood-forming organs 0.11 per cent, head 0.08 per cent, and neck 0.06 per cent.

Commenting on the approximately 10 per cent of rejections by Army physicians of men previously qualified by local board physicians, the report pointed out that local board examinations are not carried out under ideal conditions. The local boards do not have full equipment nor do they have specialists as readily available as is the case at Army headquarters. The rate of rejections declined to about 15 per cent at the end of the period from 25 per cent at first. The city's 280 local boards now have an average of two or three physicians each, compared with an original allotment of one each.

This patriotic contribution is carried on by these New York physicians gratis after their usual day's work in the private practice of medicine.

NAVY MONTHLY MEETING

Lieut. Albert R. Behnke Jr. discussed "Physiological Effects of Variations in Barometric Pressure on Naval Personnel with Relation to Aviation, Deep Sea Diving and Internal Medicine" before a meeting of the medical and dental officers of the Navy on duty in the District of Columbia and vicinity, February 3.

V 19

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION ON TRIAL

THE TRIAL OF THE CASE OF THE UNITED STATES OF AMERICA

VS.

THE AMERICAN MEDICAL ASSOCIATION, A CORPORATION, THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, A CORPORATION, THE HARRIS COUNTY MEDICAL SOCIETY, AN ASSOCIATION, THE WASHINGTON ACADEMY OF SURGEONS, AN ASSOCIATION, ARTHUR CARLISLE CHRISTIE, COURSEN BAXTER CONKLIN, JAMES BAYARD GREGG CUSTIS, WILLIAM DICK CUTTER, MORRIS FISHBEIN, THOMAS ALLEN GROOVER (DECEASED), ROBERT ARTHUR HOOE, ROSCO GENUNG LELAND, THOMAS ERNEST MATTINGLY, LEON ALPHONSE MARTEL, FRANCIS XAVIER MCGOVERN, THOMAS EDWIN NEILL, EDWARD HIRAM REEDE, WILLIAM MERCER SPRIGG, WILLIAM JOSEPH STANTON, JOHN OGLE WARFIELD JR., OLIN WEST, PRENTISS WILLSON, WILLIAM CREIGHTON WOODWARD, WALLACE MASON YATER, JOSEPH ROGERS YOUNG.

(Continued from page 1169)

FEBRUARY 27—MORNING

TESTIMONY OF BENJAMIN BRENT SANDIDGE
(CONTINUED)

(The witness identified further documents.)

Mr. Allen:—I wish to read U. S. Exhibit 473, copy of letter on the letterhead of the Central Dispensary and Emergency Hospital, dated Nov. 1, 1937, from B. B. Sandidge, superintendent of the Emergency Hospital, to Dr. Allen E. Lee:

"Dear Dr. Lee:

"Your name has been withdrawn from the list of those to whom the Courtesy Privileges of treating patients at Emergency Hospital is extended, due to the fact that we are advised you are not a member of the Medical Society of the District of Columbia."

I will now read Exhibit 474, which is a carbon copy of a letter dated Nov. 10, 1937, from B. B. Sandidge to Dr. Allen E. Lee:

"Dear Dr. Lee:

"On Nov. 1, 1937, we wrote you to the effect that your name had been withdrawn from the list of those to whom the courtesy privilege of treating patients at Emergency Hospital is extended, due to the fact that you were no longer a member of the Medical Society of the District of Columbia.

"We have since learned that this information was not correct and that your name is still on the membership roster of the District Medical Society, and I am writing to apologize for this error on our part.

"As you are aware, one of the requirements at our Institution for a doctor to be extended the privilege of treating patients at this hospital is that he be a member of the District Medical Society, and in view of the fact that your status is still such, and until we are officially notified to the contrary, you are extended courtesy privileges as was your status heretofore.

"We wish to assure you that no personal element entered into this action, and again apologizing for this misunderstanding, we beg to remain,

"Very truly yours,

"EMERGENCY HOSPITAL.

"B. B. Sandidge, Superintendent."

CROSS EXAMINATION

By Mr. Leahy:

. . . . . .

The witness named various members of the executive staff of Emergency Hospital.

By Mr. Leahy:

Q.—Tell us how many were on the Executive Staff of Emergency Hospital.

A.—Eleven.

Q.—What portion of the minutes to which your attention was directed refers to the fact that Major Blair was discussing the fact that some hospitals were granting privileges to Dr. Selders while Emergency had not; is that right?

A.—Yes.

Q.—And the minutes say there was a good deal of discussion about it, discussion at great length; is that right?

A.—Yes.

Q.—Is it not true that at that time, on Feb. 18, 1938, there was a rule of the Emergency Hospital that only members of the District Medical Society could be on the staff of that hospital?

A.—Yes.

Q.—And that rule had been in force some years, had it not?

A.—Yes.

Q.—Do you recall now what year it was that Emergency Hospital adopted the regulation that only members of the District Medical Society could be on the staff of the hospital?

A.—In 1936.

Q.—April, 1936. That was long before you ever heard of Group Health?

A.—It was prior to that.

Q.—Do you remember whether there was any particular incident which was the cause of that discussion?

A.—No definite incident that I can recall; no, sir.

By Mr. Leahy:

Q.—After you have looked over the letter, Exhibit 473, dated Jan. 27, 1938, is not that the subject of discussion which is mentioned in this minute, the permission of Dr. Selders to take Miss Abbott in Garfield when, under your rule, he could not be admitted in your hospital?

Mr. Lewin:—We object to that. The substance of the minute is in the minute.

THE COURT:—He may state whether or not that was the subject that brought about the minute which is recorded there. He may state that.

A.—Might I, in getting my dates correct, ask if this meeting was held after the letter was written to Mr. Aspinwall?

Mr. Lewin:—Obviously the witness is not testifying from his independent recollection.

THE COURT:—I do not know. I will wait and see.

Mr. Lewin:—It is perfectly obvious from that request.

THE COURT:—He may be refreshing his recollection about it.

The Witness:—Well—

Mr. Lewin:—I object to this unless the witness has an independent recollection.

THE COURT:—Do you recall what brought about that minute?

The Witness:—I believe—it is my recollection that this had some bearing on the case being transferred to Garfield and treated after it left Emergency. That was one reason for the discussion in the minutes.

THE COURT:—The next question.

By Mr. Leahy:

Q.—Is it not a fact, Mr. Sandidge, that at that time the regulation which you stated—

Mr. Lewin:—I object to that. The question is leading, and there is no necessity for it.

Mr. Burke:—This is cross examination.

Mr. Lewin:—I don't care if it is. There is no hostility from this gentleman, and there is no reason for leading an argumentative question.

THE COURT:—Cross examination always permits leading questions.

Mr. Lewin:—Not in every case, your Honor. It depends on the attitude of the witness.

THE COURT:—The rule against leading questions applies to direct examination; and it may be permitted in direct examination under certain circumstances.

Proceed.

By Mr. Leahy:

Q.—Mr. Sandidge, when the minute states that the Board of Emergency expressed its appreciation of Major Blair's support of their Courtesy Staff, does not that refer to the fact that Major Blair had supported the rule and regulation which you said had been in effect since April, 1936, that only members of the District Medical Society could practice in the hospital?

A.—That is right.

Q.—That rule did not refer, however, to emergency cases, did it?

A.—No, sir.

Q.—Because in your report, which is United States Exhibit 480, the annual report for the year ending Dec. 31, 1938, you state on one of the pages to which your attention has been directed, page 7:

"No patient is ever turned away from Emergency Hospital without treatment and advice."

Is that statement true?

A.—Yes, sir.

Q.—So that the rule referred to in the minutes and about which appreciation was expressed is the rule that a doctor cannot habitually practice his profession in your hospital until he has been admitted to courtesy privilege; is that right?

Mr. Lewin:—We object to that. The documents are in and they speak for themselves.

The Court:—I think it is argumentative. Objection sustained.

By Mr. Leahy:

Q.—Showing you, also, a letter which you wrote to Dr. Lee—and that letter is dated Nov. 1, 1937—when you wrote that letter to Dr. Lee did you write that letter also because of the rule which had been enforced since April 1936?

A.—Yes, sir.

Q.—And that is the only reason you wrote it, is it not?

A.—Yes.

Q.—There was not anything personal against Dr. Lee, was there?

A.—Not to my knowledge.

Q.—You did not write it to Dr. Lee because he was on G. H. A. staff, did you?

A.—I wrote it because we thought he had not been extended courtesy privileges, that he was not a member of the District Medical Society.

Q.—It was not because he was connected with Group Health Association in any way that you wrote the letter?

A.—No.

Q.—In other words, whether he was or was not connected made no difference; the fact was that if he was not on the staff that would bring forth that letter?

A.—That is correct.

Q.—When you found you were mistaken and he was still a member of the District Medical Society, you wrote him the next letter, did you not?

A.—Yes.

Q.—In which you apologized for the fact that you had been mistaken, and wrote and told him that his courtesy privileges were continued; is that right?

A.—That is true.

Q.—With reference to these other documents which were shown you, one as far back as July 29, 1937, and the other Dec. 2, 1937, we will not take time to read them over. You recall them when you see them, do you not, Mr. Sandidge?

A.—Yes.

Q.—Do you know whether you ever saw those in the Emergency Hospital or not?

A.—Whether I ever saw them?

Q.—Yes; either one or both of them.

A.—Yes; they came over my desk.

Q.—Do you recall what you did with them after they came over your desk?

Mr. Lewin:—Objected to. It is beyond the scope of the direct examination, perfectly plainly so. He can prove all those letters in his case.

The Court:—What would make that question germane to the direct examination?

Mr. Leahy:—I think the statement was made that they came out of the files of Emergency Hospital—

Mr. Lewin:—There is no doubt about that. This witness testified they went over his desk. Now you go further and want to know what he did with them.

Mr. Leahy:—They could have gone over his desk and then into the wastebasket.

Mr. Lewin:—Maybe they did, but this is not the way to prove it.

By Mr. Leahy:

Q.—I will ask this question. Was any action of any kind taken, if you know, with reference to these by which—

Mr. Lewin:—We object to that.

Mr. Leahy:—Pardon me—by which they were ordered to be kept in the files of the hospital?

Mr. Lewin:—Do not answer that until his Honor rules.

The Court:—He may answer that.

The Witness:—Will you put that question again?

By Mr. Leahy:

Q.—Was any action taken by your hospital under which you were directed to preserve these in the files of the hospital?

A.—None other than routine. All such matters are filed.

Q.—And you followed the routine and put them in the files?

A.—Yes.

Q.—Has your attention been directed to pages 6, 7 and 8 of this report before, Mr. Sandidge?

Mr. Kelleher:—By whom?

Mr. Lewin:—He prepared it. Is it not his report?

Mr. Leahy:—I don't know.

Mr. Lewin:—It is the report of the Superintendent. It says so.

The Witness:—Yes.

Mr. Lewin:—We object to the question.

The Court:—It is just preliminary, Mr. Lewin.

By Mr. Leahy:

Q.—This report would be made up each year in the ordinary course of your business as Superintendent; is that true?

A.—That is true.

Q.—And it is a report to whom?

A.—To the Board of Directors.

Q.—And it is a report about what?

Mr. Lewin:—Objected to. It speaks for itself.

The Court:—Of course it does.

Mr. Lewin:—Why should he characterize it then?

The Court:—When I agree with you there is no use arguing.

Mr. Lewin:—I beg your pardon, your Honor. I did not know you were agreeing with me.

Mr. Leahy:—I do not want all the details of it; but generally we have a book introduced and probably five or six hours later, on another day, something will be read from it.

The Court:—The title of the book shows what it is.

Mr. Leahy:—But I do not know what the book contains. It says, "Annual Report." I do not know what it is an annual report of.

Mr. Kelleher:—Why don't you read it?

Mr. Leahy:—All right; I will, if that is what you want.

The Court:—I want this bickering to stop. That does not get us anywhere on either side.

By Mr. Leahy:

Q.—Let us look this over together. In the first paragraph you state, on page 6, to which your attention has been drawn:

"ANNUAL REPORT OF THE SUPERINTENDENT

"In this period of changes, new systems being adopted and the general rapid pace of experimentation, in plans for the health needs and hospitalization of our people who are in need of same, it would seem appropriate at this time to take a few minutes for retrospection.

"The great need in our city, for an institution of the character of the Central Dispensary and Emergency Hospital, was manifested as far back as the year 1871, for at that time the majority of supposed-to-be trivial accidents were taken to the police stations where the police surgeon was summoned. In case he could not be located, a doctor was sent for. Much unnecessary suffering was caused by this, and the consequences of neglect (often unavoidable) were sometimes disastrous.

"Public spirited citizens quickly recognized this inadequate condition of caring for the unfortunate, and this need resulted in the establishment of the present Emergency Hospital. The Charter of Incorporation (1882) reads as follows:

The Court:—Pardon me. What is the purpose of reading that?

Mr. Leahy:—Because I want to get in, if I can at this time, the connection of this document with Mr. Sandidge.

Mr. Lewin:—I will tell you the connection. He wrote it.

Mr. Richardson:—We did not ask you to tell us.

The Court:—I have no objection, if you are reading it to the jury.

Mr. Leahy:—So that the jury will know what it is all about:

"The Charter of Incorporation (1882) reads as follows: 'That the particular object of the Association or Society is to provide a suitable building in the city of Washington, D. C., for a dispensary where all needy persons without distinction may be provided gratuitously with medical and surgical service and treatment and with medicine.'

"In the following paragraphs I will endeavor to describe briefly how well the hospital has kept faith with the public throughout these many years.

"For the first year's operation $150 was subscribed, and this, together with $278 appropriated by the Legislature of the District, was the sum total for the treatment of 511 patients.

"For the year of 1938, there was a money turn-over in the amount of $568,658.75. The greater part of this money was spent in the city of Washington, and employment was furnished to a daily average of some 344 persons on the hospital payroll, in addition to more than 100 special nurses daily engaged by the patients and other personnel in departments financed independently of the hospital proper.

"Therefore, as it stands today, from the standpoint of a financial enterprise alone, Emergency Hospital takes its place as one of the important business organizations of our city.

"The number of hospital days furnished patients for the year was 85,109.

"The number of dispensary visits furnished patients for the year was 25,118.

"The number of emergency room visits furnished patients for the year was 14,569.

"The number of ambulance trips furnished patients for the year was 3,313.

"No patient is ever turned away from Emergency Hospital without treatment and advice. If the nature of the patient's illness is a type as to make it dangerous for those patients already hospitalized, such first aid as is needed is given, and arrangements made for proper transfer.

"In living up to its charter and meeting the many demands for charity and part-charity during the year that this report covers, the hospital had to donate more than $75,000 from its own resources, with a consequent deficit for the year of $22,940.34, despite the most careful and economical management consistent with the high type of service which has been characteristic through its career.

"The hospital management is indeed grateful for the patronage of those patients who paid more than the cost of care, for this addition to cost was a direct contribution to public charity (the hospital being organized NOT FOR PROFIT). However, this type of patient was not sufficient in number at prevailing rates established in the hospital to carry all of this additional load, and philanthropic support was not as generous as in some former years. Nevertheless, the hospital authorities have followed the practice that if the hospital continues to maintain a deep regard for the health of the community as a whole, pay and free alike, the public as well as the Government will appreciate this humanitarian and necessary foresight, and will respond in due course to its financial needs.

"Aside from this great humanitarian work, which the hospital is doing, the great numbers of fine and splendidly trained young doctors and nurses who receive all or a part of their professional training here should not be overlooked. It is really inspiring to have them return, from all sections of the country, to pay a visit and speak in grateful appreciation of the excellent training they received here.

"Notwithstanding this great volume of work carried on year after year, the hospital has kept pace with modern methods and equipment. The physical plant has not been allowed to depreciate, new additions have been added. Modern equipment has been installed, such as air-conditioning units, devices for more direct communication, and many such improvements for the comfort of and service to patients and doctors."

Then follow some additions to the equipment, some of the more important highlights of 1938, such as the establishment of a blood transfusion fund, the purchase of a Bell fracture table, laboratories, and so forth, and then it says:

"The Ladies Auxiliary Board, as usual, has been active throughout the year, and we are indebted to this Board of fine women for their deep interest in the hospital and the splendid assistance they render. Their secretary's report is submitted separately, as well as reports from the various department heads."

Then "I record here with sorrow and a feeling of great loss the passing during the year" of certain people interested and closely identified with the hospital, and he signs it as his 19th Annual Report.

By Mr. Leahy:

Q.—Now, Mr. Sandidge, with respect to Emergency Hospital, is there any expense incurred in the maintenapce and operation of that hospital which is not incurred for the maintenance and operation of that not-for-profit institution in the care of the sick?

A.—All funds are used for hospital purposes.

Q.—Where your report, without going into details, marks out the number of people on the payroll, the number of nurses, and so forth, those are necessary attendants required by you in the operation and maintenance of the hospital for the care of the sick; is that right?

A.—Yes, sir.

Mr. Lewin:—We will concede that.

By Mr. Leahy:

Q.—In other words, there is no business venture in Emergency, is there?

Mr. Lewin:—Just a moment. We object to that. It is written in the report that "as it stands today, from the standpoint of a financial enterprise alone, Emergency Hospital takes its place as one of the important business organizations of our city."

Mr. Leahy:—May I have the question answered? I certainly can cross examine him about his report.

Mr. Kelleher:—Further objection, on the ground that it calls for a conclusion, your Honor.

THE COURT:—He has already stated it, I think.

By Mr. Leahy:

Q.—There is no commercial enterprise, however, in the conduct of your hospital, is there?

Mr. Lewin:—We object to that. It is a matter of opinion.

THE COURT:—It appears quite clearly that the institution is a non-profit institution. It carries on its business along that line, and all of its funds are directed to that particular purpose.

Mr. Leahy:—If it is not disputed, we will not go any further on that.

Mr. Lewin:—We have not attempted to dispute it.

Mr. Leahy:—You are going to dispute it; otherwise you would not have introduced that word "business."

. . . . . .

By Mr. Leahy:

Q.—Did you have a rule in your hospital, Mr. Sandidge, that each year the courtesy list is checked and that each year the members on the courtesy list are elected to privileges under that list?

A.—I would not say that it is a rule that it be checked each year. Automatically it is kept up to date, and each year each member of the courtesy list is notified that privileges for the ensuing year are extended.

Q.—Was there anything unusual in checking the courtesy list?

A.—Just to bring it up to date, to go over it and see that it was in correct order.

RE-DIRECT EXAMINATION

By Mr. Allen:

Q.—Mr. Sandidge, can you testify that it is a fact that every physician that used the courtesy privileges of Emergency Hospital during the year of 1937 was a member of the District Medical Society or one of the two adjoining societies?

A.—No; I could not testify that there were no exceptions.

Q.—Do you know it to be a fact that there were exceptions to that?

A.—During 1937 I could not answer that definitely, because I do not recall.

Q.—If we could show you otherwise or prove to the court otherwise, that there were other members, you would agree that that would be correct?

Mr. Leahy:—That is argumentative, of course.

THE COURT:—Yes.

By Mr. Allen:

Q.—Is it not true that as late as June 1, 1938, the staff found it expedient to make a recheck to further enforce that rule and regulation which you adopted?

A.—I think that is true; yes.

Q.—And it had not been completely enforced up to that date, which caused the staff to go ahead and attempt to enforce it strictly?

A.—When the courtesy staff file was originally made up the ruling that they had to be members of the District Medical Society was not in force, and naturally there were some doctors who were not members, and they were not automatically dropped. Some of them I feel quite sure were carried on. I mean, the courtesy list was not brought right up to date so that it would coincide with the membership of the District Medical Society.

Q.—Was it brought completely up to date as the result of this meeting of June 1, 1938?

A.—There may have been some exceptions. I do not recall the names, however.

Q.—At that late date there still might have been some exceptions, to your knowledge?

A.—Yes.

Mr. Allen:—I wish to read one paragraph from the minutes of June 1, 1938:

"A special meeting of the Executive Staff was held in Emergency Hospital. The recommendations of the courtesy committee in regard to approval or disapproval of applications for the courtesy staff were approved by the staff. It was directed that the courtesy committee carefully check the list of the doctors who had been given courtesy privileges in Emergency and who are not members of the Medical Society or their local medical societies in the case of physicians who are non-residents of the District, and that these members be notified that they must join the Medical Society, or the hospital will be obliged to revoke their privileges.

Mr. Kelleher:

Exhibit 446-A is a carbon copy of a letter written by Dr. Fishback to "Dear John," on the letterhead of the Washington Academy of Surgery, dated Dec. 9, 1937. The witness testified that the "John" referred to was Dr. John Lyons:

"I have transmitted your report to George Washington University Hospital."

The next paragraph is not important and I shall not read it, but the next paragraph is as follows:

"I am anxious to talk to you before you reach any decision on Dr. Selders, especially if there is feeling that he will be disapproved purely because of his connection here in Washington. As a matter of

policy and tact, and I believe for the good of general public attitude toward the profession, the question of his relationship to the Group Health Association, Inc., should not be permitted to enter the discussion."

Exhibit 444 is the original minutes of the defendant Washington Academy of Surgery of a meeting held on Friday, Dec. 10, 1937. I shall read only the paragraph appearing on page 2 of the minutes:

"Discussion concerning the Group Health Association ensued. It was suggested that the professional qualifications of the surgeon of that organization alone be considered, as a matter of public policy. However a motion of Dr. Sager's was passed requesting the Hospital Privilege Committee to consider the ethics of any applicant as well as his strictly surgical training and experience. Ethics were understood to be as defined by the American Medical Association. It was emphasized that investigation should include knowledge of an applicant's earlier behavior in other communities before coming to this locality."

It is signed by Dr. F. C. Fishback.

Exhibit 445 is a letter from the secretary of the defendant Washington Academy of Surgery to the Superintendent of George Washington University Hospital, Washington, D. C., dated Dec. 8, 1937, and it reads as follows:

"Sir:

"The Committee on Hospital Privileges recommends:—

1. Approval of Dr. Howard H. Strine for general surgery.
2. Approval of Dr. Carolyn S. Pincock for minor surgery.
3. Disapproval of Dr. Allen E. Lee to do general surgery.
4. Disapproval of Dr. Paul Hanet to do surgery.
5. Application of Dr. Ross Taggart is for privileges in normal obstetrics and therefore is returned without action.
6. The committee is attempting to obtain further information on Dr. Raymond E. Selders, and is not yet able to act on his application.

"Very sincerely yours,
"Secretary,"
"Washington Academy of Surgery".

Exhibit 447 is a carbon copy of a letter from the secretary of the Washington Academy of Surgery, F. C. Fishback, to Col. P. M. Ashburn, Columbia Hospital for Women, Washington, D. C., dated Jan. 31, 1938, reading as follows:

"Dear Colonel Ashburn:

"I have today been informed by the Committee on Hospital Privilege that they recommend the disapproval of the application of Dr. Raymond Selders to do general surgery.

"Very sincerely yours,
"F. C. Fishback,
"Secretary, Washington
Academy of Surgery."

Exhibits 448, 449 and 450 are letters from the secretary of the defendant Washington Academy of Surgery to Providence Hospital, Georgetown University Hospital, and Garfield Memorial Hospital, all of which are dated Jan. 31, 1938, in which it is stated that:

"The committee recommends disapproval of the application of Dr. Selders."

TESTIMONY OF FRANCIS J. EISENMAN

DIRECT EXAMINATION

Francis J. Eisenman said he is superintendent, Garfield Hospital, and was in 1937 and 1938. He identified the annual report, lists of committees and correspondence.

He listed also surgeons on the staff.

He also identified minutes of the committees.

Q.—And when extracted they would have the markings that appear here?

A.—They appear to be the proper minutes.

Q.—Is it customary for minutes to be kept of the Executive Committee?

A.—Yes.

Q.—Whose duty is it to keep the minutes of the Executive Committee?

A.—The Secretary of the Advisory Committee.

Q.—Who was he?

A.—Dr. McGovern.

Q.—Does his name appear at the end of the minutes?

A.—It does.

Q.—So, in view of that, can you say that they are the minutes of the Executive Committee called for by the subpena?

A.—As far as I know, they are the minutes.

Q.—Have you any reason to doubt it?

A.—No reason other than—

Q.—Other than what?

A.—Well, I don't know.

Q.—Do you think I brought some fake minutes to you?

A.—No; I mean I can't remember what transpired.

Q.—No; I know that. But read them over and see if they are the minutes.

The Court:—He says he has no reason to doubt it. Why cross examine him on it?

Mr. Lewin:—If your Honor is satisfied, all right. I have had trouble with this sort of thing before. If I do not ask enough questions I am not successful, and if I do I still seem to be not successful.

Mr. Richardson:—Nothing from nothing is still nothing.

Here the witness identified correspondence.

CROSS EXAMINATION

By Mr. Leahy:

Q.—I want to show you Exhibit 486. Is there any signature on that paper at all?

A.—No, sir.

Q.—Exhibit 483 was shown you, which is a carbon copy. Do you recall having seen the original of which this is a carbon?

A.—Yes.

Q.—And on the date which is mentioned there?

A.—I could not verify the date, except from the record.

Mr. Leahy:—Has this been offered?

Mr. Lewin:—No.

Mr. Leahy:—May I ask you if you plan to offer this in evidence?

Mr. Lewin:—I do not see what that has to do with it. You can cross examine on the authenticity of these documents.

Mr. Leahy:—The point is this, if your Honor please. He has simply handed up some documents and asked the witness to identify signatures thereon, and then, after the witness is excused, they are going to offer them all in evidence.

The Court:—I cannot control that, Mr. Leahy. I cannot compel the Government to offer documents.

Mr. Lewin:—If you have doubts as to their authenticity you can cross examine.

Mr. Leahy:—I know what I can do. I don't need your instructions.

Mr. Lewin:—I am sorry.

. . . . . .

TESTIMONY OF FLORA HITCH

DIRECT EXAMINATION

By Mr. Kelleher:

Mrs. Flora Hitch said she was employed by Dr. William B. Marbury as nurse-secretary. She identified his signature.

Mr. Kelleher:—I will only read a part of it. Exhibit 295-A is the questionnaire which the witness has testified bears the signature of Dr. William B. Marbury who, as the evidence shows, was a member of the Hospital Committee of the District Medical Society representing Emergency Hospital.

"1. What communication has your hospital had from Group Health Association, Inc.?

"There has been some communication, the exact nature of which is not known.

"2. What reply has your hospital made to Group Health Association, Inc.?

"In effect that patients would be accepted, but could only be treated by doctors on staff, and courtesy lists.

"3. Which, if any of the following Doctors are now members of your Medical Staff in any capacity or have privileges to practice in your hospital?"

Mr. Kelleher:—There is a checkmark opposite the name of Dr. Allen E. Lee.

"4. Is your hospital in sympathy with the policies of the Medical Soc. of D. C.?

"Yes.

"5. Is the entire Medical Staff of your hospital reappointed annually?

"Yes.

"6. Are appointments to The Medical Staff of your hospital approved by The Medical Staff?

"Yes.

"7. What governing body of your hospital finally makes appointments to The Medical Staff?

"The Executive Staff.

"8. Does your hospital require membership in the Medical Society of D. C. as a qualification for appointments to its Medical Staff?

"Yes.

"9. What percentage of the entire Medical Staff of your hospital are members of the Medical Society of D. C.?

"Supposedly 100 per cent. Not checked.

"10. Does your hospital require membership in the A. M. A. as a qualification for appointment to its Medical Staff?

"Yes.

"1. What percentage of the entire medical staff of your hospital are members of the A. M. A.?

"Supposedly 100 per cent. Not checked.

"12. Is your hospital a beneficiary of Community Chest Funds?

"Yes.

"13. Will you kindly make any other inquiry that you think might be pertinent at this time?

"William B. Marbury."

THE COURT:—What hospital is that?

Mr. Kelleher:—That is Emergency, your Honor.

TESTIMONY OF CAROLINE REECE EPPERLEY

DIRECT EXAMINATION

By Mr. Allen:

Caroline Reece Epperley was formerly Caroline Sinclair Reece. From Jan. 1, 1937, to Dec. 20, 1938, she was Executive Assistant to the President, Dr. Louis H. Taylor of Sibley Memorial Hospital.

She identified letters, minutes, roster of the staff, etc.

TESTIMONY OF BEULAH C. MUMFORD

DIRECT EXAMINATION

Mrs. Beulah C. Mumford said she was admitting nurse at Sibley Memorial from Jan. 1, 1937 to Dec. 30, 1938.

Q.—And as admitting nurse, what were your duties?

A.—To make all reservations for incoming patients from doctors as they called in, and assign the room; schedule operations; write preoperative orders, and admit the patients.

Q.—As part of your duties, if some physician called up that didn't have privileges, it was your duty to determine whether to admit him from instructions previously had by you from Dr. Taylor?

A.—Yes.

Q.—I show you a Government Exhibit, No. 496, and ask you to tell the jury what that document is.

A.—Well, that is a little memorandum for our own personal use, which we kept just as a reminder.

Q.—Did you write that?

A.—I did.

Q.—And you did it to conform with instructions given to you by—

Mr. Leahy:—Objected to; you are leading the witness.

By Mr. Allen:

Q.—How did you come to write this?

A.—Well, there were so many different people relieving in our office and we were told verbally that these particular people should not have reservations if calling, and the memorandum was written so that anyone coming in would be able to find it, because it is very hard to carry everything in your head. That is why I say it was a personal memorandum.

Q.—At whose instructions was it made?

A.—No one.

Q.—At whose instructions were you told to admit these persons?

Mr. Leahy:—She said no one told her.

Mr. Lewin:—She said some one told her not to let these people in.

THE COURT:—Who told you that?

The Witness:—The president of the hospital.

Mr. Allen:—That is all.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Mrs. Mumford, you have seen this before?

A.—Yes.

Q.—Is that all in your handwriting?

A.—No, sir; the signatures are not in my handwriting.

Q.—Would you tell us what part of that you refer to as containing the signatures?

A.—It is my handwriting down to here (indicating).

Q.—Down to the—

A.—Signature.

Q.—And whose signatures are those?

Q.—And were those people in the hospital at the time, Mrs. Mumford?

A.—Yes.

Q.—Did you pass this around to them for their signatures?

A.—We kept it in our office and asked them to read and sign it.

Q.—When you say "we," you mean those of you in the office?

A.—Yes.

Q.—And you wrote this up as your own personal memorandum?

A.—Yes.

Q.—And this language is your language?

A.—Yes.

Q.—Do you recall the date you wrote this?

A.—No, sir.

RE-DIRECT EXAMINATION

By Mr. Allen:

Q.—Who were these members and what were their duties?

A.—They were staff members and they do relieving in the admitting office at times.

Q.—Do similar work as you?

A.—Yes, sir.

(Counsel for both sides approached the bench.)

Exhibit 482, gives the names of the Advisory Committee of the medical staff as of Jan. 1, 1936. They are:

"Dr. H. C. Macatee chairman, Dr. J. W. Lindsay secretary, Dr. B. F. Weems, Dr. H. H. Kerr, Dr. F. J. Eisenman superintendent."

THE COURT:—I don't think you mentioned the hospital.

Mr. Lewin:—Garfield Memorial, and "the same Committee" with the exception of the Secretary—Dr. F. X. McGovern elected Secretary in place of Dr. Lindsay:

"On Jan. 1, 1938, Dr. H. C. Macatee chairman, Dr. F. X. McGovern secretary, Dr. A. B. Bennett, Dr. T. E. Neill, Dr. L. C. Ecker, Dr. R. L. Silvester, Dr. F. J. Eisenman superintendent.

"In October 1938 Dr. R. L. Silvester was elected as secretary of the Advisory Committee in place of Dr. McGovern."

Mr. Lewin:—Exhibit 483 is a carbon copy of a letter dated Nov. 15, 1937, from Francis J. Eisenman, Superintendent to Dr. Raymond E. Selders, 1328 Eye Street, Northwest, Washington, D. C.:

U. S. EXHIBIT 483

"My dear Dr. Selders:

"Acknowledge receipt of a request for Surgical Privileges at Garfield Memorial Hospital. Your application has been referred to the Advisory Committee for action at their next meeting.

"You, no doubt, are cognizant with the routine procedure for courtesy privileges in all Class A hospitals. We have required for the past twelve years or more that all such requests be referred to the Medical Advisory Committee of the Board of Directors for recommendation.

"This Committee is expected to meet on or about Nov. 29, 1937.

"Sincerely yours,
"Francis J. Eisenman, M.D.,
"Superintendent."

Mr. Lewin:—Exhibit 500 is the letter which the evidence shows was sent by Dr. Conklin to all the local private hospitals in Washington, and Exhibit 500 is the one to the Garfield Memorial Hospital, enclosing the so-called white list.

Exhibit 498 is another letter from Dr. Conklin to the Chief of Staff, Garfield Memorial Hospital, dated Dec. 2, 1937:

U. S. EXHIBIT 498

"Dear Doctor:

"Pursuant to formal action of the Medical Society of the District of Columbia, in session on the evening of Dec. 1, 1937, the attached resolution is sent you.

"Very truly yours,
"C. B. Conklin, M.D.,
"Secretary."

Mr. Lewin:—Enclosed is the resolution.

"THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
1718 M Street
Washington

"Resolution adopted by the Society, in session on the evening of Dec. 1, 1937:

"*Resolved*, That as a matter of educational policy the Medical Society of the District of Columbia strongly recommends that all hospitals engaged in the teaching and training of residents, interns, and nurses, where possible, follow the recommendation of the American Medical Association regarding the constitution of their entire Medical Staffs, namely, that each appointee be a member of the Medical Society of the District of Columbia or a local medical society in this immediate neighborhood and a member of the American Medical Association."

Mr. Lewin:—Exhibit 486 is the minutes of the Advisory Committee, Medical Staff, Garfield Memorial Hospital, held Dec. 6, 1937, with the typewritten signature of the secretary, F. X. McGovern, M.D. From those minutes I read:

U. S. EXHIBIT 486

"The Secretary was requested to reply to the Medical Society of the District of Columbia in regard to a Resolution passed by the Medical Society on Dec. 1, 1937."

Mr. Lewin:—The next is this reply of Dr. McGovern; it is Exhibit 484. It is signed by Dr. McGovern as Secretary, Advisory Committee, Garfield Memorial Hospital, and addressed to Dr. C. B. Conklin, Secretary, Medical Society of the District of Columbia.

U. S. EXHIBIT 484

"Dear Dr. Conklin:

"In reply to your letter of Dec. 2, 1937, enclosing the resolution of the Medical Society adopted Dec. 1, 1937, I have been requested to advise you that the present policy in force at Garfield Hospital is in conformity with the provisions of the above-mentioned resolution.

"Respectfully yours,
"F. X. McGovern,
"Secretary, Advisory Committee."

Mr. Lewin:—The next exhibit from Garfield which I would like to read is 485, and is a memorandum from Francis J. Eisenman, M.D., Superintendent, Garfield Memorial Hospital, to Surgical Service, Garfield Memorial Hospital, dated Dec. 3, 1937:

U. S. EXHIBIT 485

"Gentlemen:

"Refer for your consideration the application of Dr. Raymond E. Selders for Surgical Privileges. This is not a 'Run of Mine' case, and your action may be far reaching. Information shows him to have sufficient training for personal recognition, when compared with many now approved for courtesy privileges at Garfield Memorial Hospital. He is a member in good standing in A. M. A., County and State Medical Societies in Texas, and was returning from Massachusetts to Texas when offered the position with H. O. L. C.

"Should your recommendation be adverse, for other than personal qualifications, request they be stated, in order that the Board of Directors might have the benefit of your advice and counsel.

"Three applications sent the Academy of Surgeons, (two of which were returned the second time) on Sept. 24, 1937. They approved of Dr. DeBayle, made no comment on Dr. Carbo, and did not even return the papers on Dr. Taggart, both of whom are practicing here, awaiting action on their application.

"Application of Dr. Wm. Hollister for Jr. Associate in Surgery. No vacancy.

"Yours very truly,
"Francis J. Eisenman, M.D.,
"Superintendent."

Mr. Lewin:—Now, here comes the letter from Dr. McGovern, Secretary, Advisory Committee, Medical Staff, Garfield Memorial Hospital, addressed to Mr. C. A. Aspinwall, President, Board of Directors, Garfield Memorial Hospital. It is dated Dec. 17, 1937:

U. S. EXHIBIT 499

"My dear Mr. Aspinwall:

The following is recommendation of the Advisory Committee of the Medical Staff to the Board of Directors of Garfield Memorial Hospital:

" 'That pending the settlement of the question raised as to the ethical status of Group Health Association, Inc., and pending further study of the professional qualifications of Dr. Raymond E. Selders, that he be not granted Courtesy Privileges at Garfield Memorial Hospital, except of course in a real emergency.'

"The reason prompting this recommendation is the fact that Group Health Association, Inc., a lay corporation, is considered unethical by the Medical Society of the District of Columbia, and its legality is being questioned. Dr. Selders has been hired by Group Health Association as its surgeon. It is the opinion of the Advisory Committee that if Garfield Hospital allows Dr. Selders courtesy privileges that it would be placed in the light of aiding and abetting Group Health Association, Inc.

"Yours very truly,
"F. X. McGovern, M.D.
"Secretary, Advisory Committee, Medical Staff."

Mr. Lewin:—And the next I will read is Exhibit 487, a report which the Superintendent, Francis J. Eisenman, made to Mr. C. A. Aspinwall, on March 28, 1938. It reads:

U. S. EXHIBIT 487

"My dear Mr. Aspinwall:

"I went over the Minutes of the Executive Committee and Board of Directors for the past nine months and find the following:

"In February 10 Executive Committee meeting a letter from Mr. Kirpatrick re Dr. Selders privileges was read. No action.

. . . . . .

"Dec. 28, 1937, Executive Committee. The Committee considered the Resolution of the Medical Staff on application of Dr. Selders as follows:

" 'That pending the settlement of the question as to the ethical status of Group Health Association, Inc., and pending further study of the professional qualifications of Dr. Raymond E. Selders, that he be not granted Courtesy Privileges at Garfield Memorial Hospital, except, of course, in a real emergency.'

Discussed, accepted, and referred to the Board of Directors, recommending approval.

. . . . . .

"Meeting of the Board of Directors of March 22, 1938, the President in reviewing the proceedings stated our official connection with Group Health Association was the application of Dr. Selders for surgical privileges, the temporary privileges extended him awaiting action on the application, and the withdrawal of these privileges on recommendation of the Medical Staff, (As noted in Resolution Executive Committee meeting of Dec. 28, 1937), awaiting legality of Group Health Association. The actual disqualification of Dr. Selders application was by the Board of Directors at meeting on Jan. 25, 1938, in which the Minutes of the Executive Committee meeting of Dec. 28, 1937, were read.

" 'In approving these Minutes, the Board desired to state that in denying the privileges of the Courtesy Staff of the Hospital to Dr. Raymond E. Selders on the recommendation of the Medical Staff of the Hospital, the action was pending the legality of the Organization who employed Dr. Selders.'

. . . . . .

"Yours very truly,
"Francis J. Eisenman, M.D.,
Superintendent."

TESTIMONY OF CLAUDE C. CAYLOR

DIRECT EXAMINATION

By Mr. Allen:

Claude C. Caylor was Secretary, Providence Hospital. He identified the roster, minutes and correspondence.

Mr. Leahy:—I will now read Exhibit 501. It is on the stationery of the X-Ray Department, Providence Hospital, Washington, D. C. There is a hand-written notation in the right hand corner "Copy of letter sent by me to non-members of the D. C. Medical Society," signed "C. C. Caylor."

The letter reads:

"As a result of the recent inspection of Providence Hospital by the Council on Medical Education and Hospitals of the American Medical Association, we have been reminded that several of our Staff members are not members of the American Medical Association or any of its constituent societies. This is one of the requirements to be met in order to be acceptable for approval for intern training, and at a recent meeting of the Executive Staff it was voted to request all members of the Staff to cooperate in meeting this requirement.

"The Staff has instructed me to inquire if you will not cooperate with it in meeting this requirement?

"If you are now a member of the American Medical Association or any of its constituent societies, please let me have that information.

"Yours very truly,"

Mr. Allen:—Now I will read Exhibit 502:

"U. S. EXHIBIT 502.

"MINUTES OF THE EXECUTIVE STAFF

"Nov. 18, 1937.

"The meeting was called to order by the President Dr. Mundell, with Sisters Rosa and Gertrude, and Drs. Fadeley, Putzki, Cahill, Duehring, Sanderson, O'Donnell, Moody, Hess, Leibell, Caylor, Higgins and Argy present.

"The minutes of the October meeting were read and approved.

"The report of the intern committee was approved."

Mr. Allen:—I am going to omit the next paragraphs of the minutes, which deal with other matters, and go down to the last paragraph:

"Correspondence between the Group Hospital Association and the Hospital was read relative to the admission of beneficiaries of the Association to the hospital, and the care of such patients. It was brought out that such patients would be admitted in accordance with the regulations of the hospital, and that physicians in the employ of the Association should first obtain hospital privileges in the usual manner before they could attend such patients.

"The meeting then adjourned.

"C. C. Caylor,
Sec."

Mr. Allen:—I now read Exhibit 503, dated Feb. 17, 1938. It is from Dr. Caylor to Dr. Raymond E. Selders.

"U. S. EXHIBIT 503

"Dear Dr. Selders:

"I regret to inform you that your application for privileges to practice in Providence Hospital has been disapproved by the Staff.

"Yours truly,
"Claude C. Caylor, M.D.,
Secretary."

Mr. Allen:—Exhibit 504 is the Regular Staff for 1938, which I won't read at this time.

Government's Exhibit 506 is a letter from Dr. Conklin to the Chief of Staff, Providence Hospital, dated Dec. 2, 1937, and encloses the December 1st resolution, which has been read several times and which Mr. Lewin read just a few minutes ago.

TESTIMONY OF MARIAN DANIEL GODBOLD

DIRECT EXAMINATION

By Mr. Kelleher:

Mrs. Godbold was employed with the Columbia Hospital for Women during the years 1937 and 1938 as Secretary to the Superintendent of the Hospital, Colonel Ashburn.

She identified minutes and correspondence.

FEBRUARY 27—AFTER RECESS

(Counsel for the defendants presented a formal objection to the admission of evidence concerning the hospitals.)

TESTIMONY OF DR. FRED O. COE

DIRECT EXAMINATION

By Mr. Timberlake:

Fred O. Coe was a member of the Executive Staff of Georgetown Hospital during 1937 and 1938. He identified Dr. Dardinski's signature.

Dr. Dardinski was charged with taking the minutes of meetings of the executive staff.

TESTIMONY OF MATTIE M. GIBSON

DIRECT EXAMINATION

By Mr. Allen:

Mattie M. Gibson was superintendent of the Children's Hospital from Jan. 1, 1937, to Dec. 20, 1938. She identified minutes of the board of directors, minutes of the medical staff, the roster of the staff and correspondence with Drs. Conklin and Scandiffio.

Mr. Lewin:—I should like now to read to the jury from the correspondence pertaining to Sibley Memorial Hospital.

Exhibit 492 is a list of the medical staff of Sibley Hospital for 1937, and Exhibit 477 is a list of the medical staff for 1938, and I will not read them.

No. 494 is an old friend, which I will not read again. It is a letter from the District Medical Society, from Dr. Conklin, this time, to the Sibley Hospital, dated July 29, 1937, and its enclosure is the White List of approved persons which omits the name of Group Health Association, Inc.

Mr. Leahy:—You might omit calling it the White List. You objected so strenuously to the term "check-off."

Mr. Lewin:—You just want a little tit for tat. All right.

I will read to the jury the response from Dr. Lewis H. Taylor, president of Sibley Memorial Hospital, to that letter enclosing the approved list. It is Exhibit 493, dated Aug. 26, 1937, addressed to the Medical Society of the District of Columbia, Dr. Coursen B. Conklin, Secretary:

"I wish to acknowledge receipt of your communication of July 29, 1937, relative to the action of the Executive Committee of the Medical Society of the District of Columbia on July 12, 1937 in fulfilment of Chapter IX, Article IV, Section 5 of the Constitution.

"I have had this communication placed in the appropriate file of the Hospital and its provisions will be carried out by this institution.

"Very sincerely yours,
"Lewis H. Taylor, M.D.
"President."

The next one is an old friend. You don't mind my calling it that, do you, Mr. Leahy? It is Exhibit 495 and it is also a letter from Dr. Conklin, Secretary of the District Medical Society, to the Chief of Staff of Sibley Memorial Hospital, dated Dec. 2, 1937, and it encloses a resolution of the Society adopted on the evening of Dec. 1, 1937.

Here is the response of the president of Sibley Memorial Hospital to that communication. It is Exhibit 490, dated Dec. 6, 1937, and addressed to Dr. C. B. Conklin, Secretary, The Medical Society of the District of Columbia, and it reads as follows:

"My dear Doctor Conklin:

"I wish to acknowledge receipt of your letter of Dec. 2, 1937 referring to the action of the Medical Society on Dec. 1, 1937 and also the inclosed resolution. My impression is that membership in the Medical Council of this institution is already on the basis suggested in the resolution. There are no changes in the Council's personnel in contemplation at present, but should such contingency arise, you will know that proper regard will be paid to the wishes expressed in the aforementioned resolution.

"With kind personal regards to you, I am

"Very sincerely yours,
"Lewis H. Taylor, M.D.
President."

Before continuing reading the documents of the Sibley Memorial Hospital I would like to turn to the minutes of the Executive Committee of the defendant District Medical Society for April 11, 1938, and I will read from page 3. I had better tell you who was present. The defendant Dr. William Mercer Sprigg presided, and there were present Drs. Borden, Chipman, Claud, Fowler, Holden, Hooe, Gill, McGovern,, Murphy, Neill, Reed—John A. Reed and E. Hiram Reede—Lomax Wells and C. B. Conklin.

On page 3, after a lot of colloquy, I read the following:

"At this point Dr. F. X. McGovern asked to be heard. He stated that he had, he believed, the proper interests of the Medical profession at heart. He was of the opinion that frequent press releases would be playing into the hands of the Group Health Association. Furthermore, he had attended a luncheon at which Dr. William C. Woodward and Dr. Wright were present, and that Dr. McGovern's action relative to the press had been commended. It was apparent to Dr. McGovern that the Group Health Association, as such, was licked and that it was a very small affair compared with the much larger, national in scope, movement that was now under way. He did believe that for these reasons certain proposals by Mr. Fulton Lewis Jr. were made without sufficient knowledge of the full implications."

Then, turning to page 6:

"Dr. McGovern was recognized and said it was plain that the questions that Dr. Hooe had propounded to Mr. Lewis came from Mr. Lewis and that he wanted to make it plain that he believed the Group Health Association was now nothing but a bubble. He cited what he succeeded in getting in the press personally, ending by saying that since The Post printed an editorial inspired by him (Dr. McGovern) Mr. Kirkpatrick hasn't opened his mouth. He resented strongly his being on trial, which it was very plain that he was.

"Dr. Hooe was recognized. He stated that he had not made any plea for Mr. Fulton Lewis' services tonight—just presenting facts. He added that he had another very important matter to bring before the committee—that was relative to the hospitals. He thought that a meeting should be arranged in the Medical Society Building, to which would be invited the official representatives of the various hospitals. He stated that the hospitals had been cooperative. He thought that the Society should get the representatives all together with view to expressing appreciation and standardizing action against the Group Health Association group physicians.

"Dr. Hooe would make a motion that the Chairman of the Executive Committee be authorized and directed to appoint a committee, consisting of many members, including such doctors as Drs. A. C. Christie, F. X. McGovern, W. M. Sprigg, Sterling Ruffin and others, to perfect arrangements and conduct the meeting.

"The secretary offered an amendment to the effect that the Compensation, Contract and Industrial Medicine Committee, with certain supplementary additions, operate the meeting. Dr. Hooe thought his original plan was to be preferred.

"The motion as originally made was seconded and adopted."

The minutes are signed by the defendant C. B. Conklin, Secretary.

I should like to read, also, from the minutes of the Annual Stated Meeting of the Medical Society of the District of Columbia held Wednesday, May 11, 1938, at 8 p. m.:

"Dr. Thomas E. Neill, president, presiding.

"Present: Drs. Vaughan, Prentiss, Trinder, Elward, Fong, Talbot, Reede, Alfaro, Thompson, Gwynn, Rench, Thomas, Barry, Mallory, Leonard, Foye, Arnold, King, Fowler, Christie, Clark, and other members to the number of about 460.

. . . . . .

"The minutes of the preceding meetings held April 27 and May 4 were read and approved."

Now I should like to turn to page 14:

"Dr. R. Arthur Hooe was recognized. He made a motion to the effect that the Medical Society of the District of Columbia go on record as forbidding its members to receive monies or checks for services rendered to beneficiaries of Group Health Association, Inc., or its agencies and so notify the membership of the Medical Society.

. . . . . .

"Dr. Hooe was confident that the Legal Department of the American Medical Association would render an opinion consistent with the motion. He said he had conferred with counsel for the Society and upon request read a communication that had been addressed to the Secretary, as follows:

" 'May 10, 1938.

" 'Dr. C. B. Conklin, Secretary,
Medical Society, D. C.
1718 M St. N.W., Washington, D. C.

" 'Dear Dr. Conklin:

" 'Mr. George F. Hoover tells me that he has received from Dr. Hooe a request for information which it is understood is desired by the Medical Society, namely, as to whether members of the Society should accept payment for services rendered members of Group Health Association.

" 'Mr. Hoover, Mr. Leahy and I have considered the subject and it is our advice that members of the Medical Society should not accept any payments whatsoever from Group Health Association and should issue no receipts in favor of said Association; and that with respect to treatment rendered patients who happen to be members of Group Health Association, the physician who renders the treatment can accept payments made directly by the patients.

"Very truly yours,
" 'F. A. Fenning.'

"Dr. C. B. Conklin made a motion that this matter be referred to the Executive Committee for consideration and report. No second to this motion.

"Dr. W. Raymond Thomas made a motion that the matter be laid on the table. Seconded and not adopted.

"Dr. Hooe restated his motion to the effect that the Medical Society of the District of Columbia go on record as forbidding its members to receive monies or checks for services rendered to beneficiaries of Group Health Association, Inc., from or over the signature of Group Health Association, Inc., or its agencies and so notify the membership of the Medical Society. Seconded and finally adopted."

And the minutes are signed by C. B. Conklin, Secretary.

I will resume the reading of the Sibley Memorial Hospital correspondence.

Government Exhibit 417 is a letter from Dr. Lewis H. Taylor, president of Sibley Memorial Hospital, to Mr. William C.

Kirkpatrick, President, Group Health Association, dated Feb. 5, 1938, which reads as follows:

"My Dear Mr. Kirkpatrick:

"I am returning you herewith a check of the Group Health Association for $66.80 on which there is a notation 'hospitalization for Miss Tommie Lee Nix.' This check was evidently sent to us by mistake. As you are aware from correspondence between your predecessor, Mr. William F. Penniman, and myself, as President of Sibley Memorial Hospital, the application of Group Health Association to this institution for the admission of its members is still under advisement. The Board of Directors of this institution have arrived at no conclusion in the matter and pending their decision, of course, none of your Group, as such, are eligible for hospital privileges here.

"For your information, I may state that Miss Tommie Lee Nix on Dec. 24, 1937 was admitted to this hospital on the service of Dr. Rush Conklin. Later, she was transferred to the service of Dr. A. B. Little and was then operated on by Dr. Oliver Cox. On her admission card, responsibility for her bill is assumed by and over the signature of James R. Nix, 2900 Seventeenth St. N.E., and we look to this gentleman or the patient, Miss Tommie Lee Nix, for the settlement of her account.

"Very sincerely yours,
"Lewis H. Taylor, M.D., President."

The next is Government Exhibit 491, and it is a memorandum to Admission Office, Accounting Department, from Lewis H. Taylor, president of Sibley Memorial Hospital, dated Feb. 8, 1938:

"Please use every precaution to see that no patient is admitted as a member of the Group Health Association, Inc., of the Home Owners' Loan Corporation. Also, that all checks in payment of service rendered patients be scrutinized closely to see that they are not made out by this organization. The reason for this memorandum is that Group Health Association, Inc., has applied for the privilege of having their members admitted to this hospital and that their application is still pending and has not been acted on by the Local Board of Directors.

"Lewis H. Taylor, M.D., President."

Exhibit 496 is a handwriting memorandum which was identified by the witness Mumford on the stand this morning. In handwriting it says:

"Group Health Association, H. O. L. C.
"Dr. Henry Brown, Director,
"Dr. Raymond Selders, Surgeon
"Dr. Allen Lee
"Dr. Edmund Wells
"Dr. Stephen Hulburt
"Dr. M. Scandiffio.
"These doctors are not to be allowed in at any time.
"L. Welch
"Beulah Mumford
"H. R. Dutton
"D. A. Wood
"J. Jensey
"M. M. Realine."

The next is Government Exhibit 418, which is Mr. Kirkpatrick's reply to Dr. Taylor in regard to the Nix check, dated Feb. 18, 1938:

"My Dear Dr. Taylor:

"I am in receipt of your letter of Feb. 5, 1938 with which you return a check issued by Group Health Association, Inc., bearing number 247, in the amount of $66.80, to the order of Sibley Memorial Hospital. This check is in payment of a bill dated Jan. 5, 1938 rendered by your hospital for services rendered to Miss Tommie Lee Nix, a member of this Association, while confined in your hospital from December 24 to December 31, 1937.

"In your letter you state that the check was evidently sent to you in error and refer to the fact that on the stub of the check there is a notation which reads 'hospitalization for Miss Tommie Lee Nix.' We wish to advise there was no mistake on our part in transmitting the check in question. Under provisions of the by-laws of Group Health Association, Inc., Miss Nix is entitled to have provided to her hospitalization when such is necessary. Miss Nix having received hospitalization in your institution for the dates mentioned is therefore entitled to have the cost of that hospitalization paid for by Group Health Association, Inc. Your attention is invited to the fact that the stub which contains the notation referred to is not in any sense a part of the body of the check. The stub is provided only for information of the payee as to what the check is intended to cover. In depositing the check, if you so choose, the stub of course may be detached before the check is deposited. We are, therefore, returning the check herewith and ask that it be deposited in the usual course.

"In the first paragraph of your letter you state that application of this Association to admit its members to your hospital is yet under advisement by your Board of Directors and that until a conclusion is reached members of Group Health Association, Inc., are not entitled to receive the privileges of your hospital. I gather from your letter that because patients may be members of Group Health Association, Inc., they are by that fact not entitled to be treated at Sibley Memorial Hospital until such time as your Board has approved their admission as such members. It is difficult for us to appreciate this conclusion. We understand that hospitals in the District of Columbia are maintained for the service of members of the community and that those comprising the community may enjoy the privileges of treatment at those hospitals when necessary and that membership in Group Health Association, Inc., could hardly be regarded as a reason for denying such persons admission to your hospital when such is necessary. I do not believe that the Methodist Episcopal Church, which we understand is the owner of Sibley Memorial Hospital, would approve such a policy.

"We can well understand that admission to your courtesy staff of any member of the staff of physicians of Group Health Association, Inc., is entirely within the discretion of the authorities of your hospital and that you have every right to insist that any physician or surgeon admitted to courtesy privileges in your hospital should first establish beyond all doubt the fact that he is in every respect qualified for admission to the courtesy staff. We cannot, however, comprehend that citizens of the District of Columbia when in need of treatment at your hospital should be denied that privilege merely because they are members of this Association.

"Very sincerely yours,
"W. C. Kirkpatrick, President."

To which the president of Sibley Memorial Hospital makes response by letter dated Feb. 21, 1938, Exhibit 419, as follows:

"My dear Mr. Kirkpatrick:

"I wish to acknowledge receipt of your letter of Feb. 18, 1938 addressed to me as President of Sibley Memorial Hospital and returning to me a check, numbered 247, issued by the Group Health Association, Inc., in the amount of $66.80, said check made to the order of Sibley Memorial Hospital and dated Jan. 17, 1938; the purpose of this check as indicated on its stub, 'Hospitalization for Miss Tommie Lee Nix.'

"Miss Tommie Lee Nix was admitted to the Hospital on the service of Dr. Rush Conklin on Dec. 24, 1937. Miss Nix signed her own card of admission on which appears the name of her brother, James R. Nix, 2900 17th Street, N.E., who assumed responsibility for the payment of her bill while in this institution. On her admission card appears no reference whatsoever to the Group Health Assoiation, Inc. It should be apparent that pending the decision of the Local Board of Directors of Sibley Memorial Hospital, who are considering the request of your Association, the institution would not receive your members as such. This Hospital is open to citizens of the District of Columbia and the surrounding country and has been since its foundation over forty years ago. The fact that an individual is a member of any organization, yours or otherwise, has nothing to do with entry to Sibley Hospital. I am therefore, returning your check, $247. We confidently expect and know that Miss Nix or her brother who signed responsibility for her bill, will settle this account.

"Very sincerely yours,
"Lewis H. Taylor, M. D., President."

The next is Government Exhibit 420. It is on the letterhead of Group Health Association, Inc., and comes from R. T. Berry, Secretary-Treasurer, Group Health Association, Inc., addressed to Dr. Lewis H. Taylor, M.D., President, Sibley Memorial Hospital, dated March 30, 1938:

"Dear Dr. Taylor:

"We have again received our check 247 in the sum of $66.80, drawn to your order for hospitalization incurred by Miss Tommie Lee Nix.

"We regret that you seem to be unable to accept payment for an apparent just debt. We wish to inform you that the expense so incurred by Miss Nix is payable by this association and any delinquency in payment as may appear on your records is due entirely to the fact that this check has not been accepted and we wish you to understand that the credit standing of Miss Nix in the District of Columbia or elsewhere is not to be affected in any way, pending your decision as to whether or not you will definitely decline or accept this check.

"When you wish payment, kindly notify this office and we will again forward you the check to clear your records.

"Very truly yours
"R. T. Berry, Sec'y.-Treas.,
Group Health Association, Inc."

That was in March. Next we see in June Government Exhibit 421 from Lewis H. Taylor, M.D., President of Sibley Memorial Hospital, to W. C. Kirkpatrick, President of Group Health Association, Inc.:

"June 20, 1938.

"My dear Mr. Kirkpatrick:

"I am returning to you herewith, a check of the Group Health Association, numbered 931, in the amount of $31.00, on which there is a notation 'for board, drugs, and laboratory service, Miss Taylor Owen.'

"Miss Taylor Owen was admitted to Sibley Hospital on May 23, 1938, on the service of her physician, Dr. A. McNitt. On her admission record, responsibility for her account was assumed by her sister, Miss Moss Owen.

"Similar action was taken in the case of Miss Tommie Lee Nix and the reasons therefore were plainly stated in correspondence between you and myself and may be found in my letters to you.

"The Local Board of Directors have not arrived at no decision in the matter of the application of Group Health Association for certain privileges in Sibley Memorial Hospital. I will communicate to you promptly any action which they may take in the matter.

"Very sincerely yours,
"Lewis H. Taylor, M. D., President."

Here comes Mr. Kirkpatrick's response, Government Exhibit 422, dated Aug. 5, 1938, addressed to Dr. Lewis H. Taylor, President, Sibley Memorial Hospital:

"Dear Dr. Taylor:

"This will acknowledge receipt of your letter of June 20, 1938 with which you return our check 931 in the amount of $31.00 for Board, Drugs and Laboratory Service to Miss Taylor Owen, a member of

Group Health Association, Inc. The check in question is returned herewith together with a request signed by Miss Owen that you accept the check as tendered.

"Very truly yours,
"W. C. Kirkpatrick, President."

The enclosure is the communication referred to of Aug. 5, 1938, to Sibley Memorial Hospital, reading as follows:

"Dear Sirs:

"This is to advise you that Group Health Association, Inc. has been by me requested to make payment to you of the indebtedness due you of $31.00 arising out of your recent services to Miss Taylor Owen.

"If for any reason you do not accept the tendered payment, you will kindly advise Group Health Association, Inc., the basis of your refusal as I expect to leave settlement of this indebtedness entirely with the Association, and have given it full authority to act for me in the premises."

To which the president of Sibley Memorial Hospital, on Aug. 12, 1938, makes response, Government Exhibit No. 423, as follows:

"Aug. 12, 1938.

"Miss Taylor Owen,
2019 Eye Street, N.W.
Washington, D. C.

"My dear Miss Owen:

"Receipt is acknowledged of your letter of Aug. 5, 1938, enclosing check of Group Health Association No. 931, in the amount of $31, payable to the order of Sibley Memorial Hospital. Said check is returned to you herewith.

"It is requested that you pay the amount of your indebtedness to this hospital in cash.

"Yours very truly,
"Lewis H. Taylor, M.D., President."

Government Exhibit No. 424 is Mr. Kirkpatrick's letter dated Aug. 26, 1938:

"Dear Mr. Taylor:

"This will refer to your letter of Aug. 12, 1938, addressed to Miss Taylor Owen, 2019 Eye Street, N.W., Washington, D. C., which letter has been referred to the writer for attention by Miss Owen.

"Miss Owen has previously notified you that this Association is acting in her behalf with respect to the hospital bill amounting to $31.00 due you.

"You will find enclosed our check No. 931, which was previously forwarded to you and which was returned with your letter to Miss Owen, now duly certified by the Riggs National Bank.

"If for any reason you do not see fit to accept this certified check, advice as to the basis of your refusing to do so will be appreciated.

"You can readily understand the considerable trouble which would be involved in making a formal legal tender in cash to you of the amount in question. I feel certain that your attitude will not be such as to require us to resort to this extremity.

"Very truly yours,
"W. C. Kirkpatrick, President."

To which the president of Sibley Memorial Hospital, Dr. Lewis H. Taylor, on Aug. 30, 1938, makes response, Government Exhibit 425, as follows:

"Dear Miss Owen:

"Receipt is acknowledged of a letter of Group Health Association dated Aug. 26, 1938, with the enclosure being a certified check in the amount of $31.00 therein referred to. Said letter purports to have been sent in your behalf.

"The check is returned to you herewith, with the request, as previously made in our letter addressed to you under date of Aug. 12, 1938, that you pay the amount of your indebtedness to this Hospital in cash.

"Yours very truly,
"Lewis H. Taylor, M.D., President."

Government Exhibit 426 is a somewhat similar letter from the same Dr. Lewis H. Taylor, president of Sibley Memorial Hospital, this time to Mr. Howard F. Vickery, another member of Group Health Association, in regard to refusing payment of Group Health Association's check for his account. It is dated Aug. 2, 1938. I will not bother to read that, nor will I read at this time Government Exhibit 427, which is Mr. Kirkpatrick's letter in regard to the Howard Vickery case, which enclosed the authorization of Mr. Vickery to the Sibley Memorial Hospital to accept check. Nor will I read the letter dated Aug. 12, 1938, in regard to a similar matter. Nor will I read Government Exhibit 429, which is Mr. Kirkpatrick's letter to Sibley Memorial Hospital dated Aug. 13, 1938. Perhaps I should give you the last word in this series. I do not think it is necessary to read it, however. It is exactly like one of the others that I read. This is as late as Aug. 30, 1938. It is Exhibit 430, Dr. Taylor's letter to Howard Vickery, finally refusing a certain check and demanding cash.

Mr. Kelleher:—I wish now to read the documents which were introduced through the witness from Columbia Hospital.

Exhibit 507 is the minutes of a meeting of the Executive Committee of Columbia Hospital, dated Dec. 2, 1937:

"(b) the Hospital Committee of the Medical Society of the District of Columbia has recommended to the Society that all members of the staffs of all hospitals in the District be asked to join the Medical Society of the District or the American Medical Association, but the District Medical Society has not yet acted upon the recommendation."

Then, turning to page 2 of the minutes, I read the following, which is still part of the Superintendent's report:

"The Superintendent reported correspondence with the Group Health Association within the Home Owner's Loan Corporation, indicating, on the part of the Association, a desire to have its members accepted for hospitalization at customary rates, and that Dr. Selders, one of its employees, be allowed to treat such members when hospitalized here. The Superintendent had replied that the hospital would doubtless be willing to accept members of the Association at the customary rates, but that no physician could practice here until appointed to either the regular or courtesy staff by the Board of Directors. Following this, Dr. Selders made application in Classes 1, 2 and 3, which application is now under consideration by a committee appointed within the Medical Board, because the application did not show the special training and large experience in Obstetrics and Gynecology which are usually demanded of applicants for privileges in Classes 1 and 2.

"The Superintendent further reported a visit from Mr. Penniman of the Home Owner's Loan Corp., who explained the objective of the cooperative society and expressed a desire to work in the most harmony with physicians and hospitals, stated that the cooperative society expects to pay but $4 per day toward the hospital expenses of its members and that those members must themselves pay any additional charges. He asked that pending action upon Dr. Selders' application for privileges, temporary approval be granted him in case of emergency work or obstetrics. The Superintendent informed Mr. Penniman that privileges would be granted for cases of normal obstetrics pending the decision.

"Dr. Sprigg, a representative of the Medical Board, counseled delay in action upon both the requests made by the Group Health Association and Dr. Selders pending legal decision at present being sought in regard to the Association, and that meanwhile emergency cases requiring hospitalization be accepted as a measure of humanity. The Superintendent asked if the Committee had any instructions as to how he should proceed in case of request for admission of patients and was advised, upon motion of Mr. Blair, that action in such cases be left to his judgment. Mr. Lesh then stated that, if it were true, he thought that it should be made a matter of record that the Superintendent's action and the proposals now made meet with the approval of the Medical Staff and, upon assurance by Dr. Sprigg that such is the case, it was decided to make a record of the fact."

U. S. EXHIBIT 508

Mr. Kelleher:—Exhibit 508 is the minutes of the meeting of the Board of Directors held on Wednesday, Sept. 21, 1938, at 3:30 o'clock p. m. I will read the following paragraph:

"The Medical Board reported as follows on the applications for courtesy privileges:

"Dr. Raymond E. Selders, Classes 1 and 3, the Medical Board informs the Board of Directors that it considers it inadvisable to act at this time on the application of Dr. Selders."

Now I read paragraph D:

"The Superintendent reported 'Group Health has asked for the granting of privileges to its doctors. Captain Wells had informed them that action might be taken at this meeting. The action on Dr. Selders' application indicated above is the answer."

Mr. Leahy:—Will you not read what is above that?

Mr. Kelleher:—I have read it; I will read it again if you like. I have no desire to read the rest of the paragraph D, unless you want me to.

"The Medical Board reported that it considers it inadvisable to act at this time on the application of Dr. Selders."

Mr. Kelleher:—Exhibit 511 is the minutes of the Medical Board of Columbia Hospital, Dec. 9, 1938:

"U. S. EXHIBIT 511.

"The following applications for hospital privileges were considered. Dr. Clark P. Halstead, Class 3, postponed pending further information," and the minutes show that the applications of two other doctors were postponed at the same time. Unfortunately, I have read some of these minutes out of order. I would like to read the minutes of the Medical Board for Sept. 19, 1938:

"Dr. Sprigg moves to consider the application of Dr. Selders for privileges in Classes 1 and 3, and that he not be endorsed for the privileges. This was seconded by Dr. Mundell and discussed by Drs. Sprigg, Wilson, Sylvester, McNitt, Mundell and Copeland, after which, Dr. Wilson moved that the following be substituted for Dr. Sprigg's motion:

"'That the Medical Board inform the Board of Directors that it considers it inadvisable to act at this time on the application of Dr. Wilson.'

"This was seconded by Dr. Sylvester and was carried by five to two. Dr. Wilson then moved the adoption of his substitute. Dr. Sylvester seconded the motion and it was passed by a vote five to two."

Mr. Kelleher:—Exhibit 514 is the letter of the defendant Conklin dated July 19, 1937, to the Superintendent of the Hospital, enclosing the list of approved organizations.

Exhibit 515 is the letter from Dr. Conklin to the Chief of Staff of Columbia Hospital dated Dec. 2, 1937, and enclosing the resolution of the Medical Society adopted on Dec. 1, 1937.

Mr. Timberlake:—May it please the Court, I will now read from Government's Exhibit 440-A, a letter from Sister M. Rodriguez to C. B. Conklin, Secretary, The Medical Society of the District of Columbia, dated Dec. 7, 1937:

"U. S. EXHIBIT 440-A

"My dear Dr. Conklin:

"I am in receipt of the copy of the Resolution adopted by the Medical Society of the District of Columbia.

"It gives me pleasure to state that the Executive Staff of the Georgetown University Hospital, in session on Oct. 11, 1937, acting on the recommendation of the American Medical Association concerning the approval of Residencies and Internships ruled as follows:

"That all members to the Courtesy Staff shall be nominated and elected annually and that no physician shall be nominated or elected to any staff of the hospital unless he is a member of his local or County Medical Society and of the American Medical Association. Members who are already on the staffs, as well as those who are applying for privileges to practice in the hospital, shall be notified to qualify within the year.

"Thanking you for past courtesies, I am,

"Sincerely yours,
"Sister Mary Rodriguez,
"Superintendent."

Mr. Timberlake:—Government's Exhibit 516 is the minutes of the "Special Committee of the Executive Committee on Hospital Administration" held Jan. 20, 1938, in the staff room of the hospital, Father McCauley presiding.

"U. S. EXHIBIT 516

"Special Meeting of the Executive Committee on Hospital Administration

"Special meeting of the Executive Staff was held Jan. 20, 1938, at 4 p. m. in the staff room of the hospital, Father McCauley presiding.

"Those present were Drs. Coe, Martel, Whitmore, Vaughan, Koppanyi, Mollari, Cavanaugh, Cahill, Schnitzky, Milone, Mundell, Stanton, Duehring and Dardinski.

"Sister Rodriguez presented the case for consideration which concerned a patient admitted from the H. O. L. C. The question to be decided:

"1. Was the patient now (after 48 hours) to be considered an emergency case.

"2. Would Dr. Selders be allowed to treat the case in spite of the fact that his credentials had not yet been approved.

"Dr. Vaughan felt that the case was no longer an emergency and that Dr. Selders should not be allowed to continue with the case.

"Dr. Coe said the case must be taken care of and that he had been in consultation with Dr. Selders on the case and had advised him to have orthopedic consultation.

"Dr. Cahill thought we should take action, since we had no report from the Washington Academy of Surgery we should act ourselves. He said Dr. Selders is not qualified and a case is no longer an emergency after 48 hours.

"Dr. Martel thought that Mr. Penniman was pressing Sister on a good opportunity. Being an emergency case Sister consulted with Drs. Coe, Martel, Duehring and Dardinski. All agreed to admit patient as emergency. Now we must consider is the case still emergency. If patient is moved what would be the consequences. Furthermore Dr. Selders says he doesn't care who treats the patient but patient must pay doctor. They will not.

"Dr. Stanton said that Dr. Coe had suggested treatment and Dr. Selders is not taking advice. Best interests of patient to be considered first. Case is no longer an emergency.

"Dr. Coe thought that Dr. Selders can do it only with consultation of staff member.

"Dr. Martel moved that Dr. Selders be informed case ceases to be an emergency and should cease treating case.

"Dr. Vaughan again stated that case was not an emergency. The case now could wait a week. Dr. Selders has no right to handle case and now it becomes hospital case. He should not be allowed to operate but courtesy of being present when man operates should be extended to Dr. Selders.

"Dr. Coe described the operation.

"Dr. Mundell thought there were many angles to the case and expressed himself in favor of allowing Dr. Selders to go on with the case.

"Dr. Koppanyi suggested we defer action until we see what other hospitals do.

"Dr. Duehring felt that case should be treated by Dr. Selders to avoid trouble.

"Dr. Vaughan does not agree with Drs. Duehring, Koppanyi and others in favor of allowing Dr. Selders to continue with case.

"The original motion of Dr. Martel's withdrawn. Dr. Martel moved that emergency no longer exists.

"Passed 5 no, 10 yes.

"Sister Rodriguez moved that although permission was given to treat the case now that the case has become operative it must be done under supervision of one of our approved orthopedic surgeons according to the rules of the hospital.

"Passed unanimously.

"Dr. Cahill moved that surgical privileges be withdrawn from Dr. Damian. Dr. Coe seconded. Passed unanimously.

"Motion made to adjourn.

"V. J. Dardinski, M.D.,
"Secretary."

U. S. EXHIBIT 517

Mr. Timberlake:—Now I read from Exhibit 517, which are the minutes of a "Special Meeting of the Executive Committee on Hospital Administration," held Thursday, March 10th:

"Special Meeting of the Executive Committee on Hospital Administration

"A special meeting of the Executive Staff was held Thursday March 10th at 12 noon. Father McCauley presiding.

"Those present were Sister Rodriguez, Drs. Hird, Vaughan, Martel, Koppanyi, Cavanaugh, Mollari, Wall, Milone, Solnitzky, Duehring, Cahill, Coe, Mundell, Cutting, and Dardinski.

"Subject for consideration was the letter sent out by the Group Health Organization, Inc., inviting members of the Hospital Staff to attend meeting which was to be held Friday, March 12.

"This letter was read by Father McCauley.

"Dr. Coe read a motion which after suggestions and amendments by Drs. Hird, Wall and Duehring finally read as follows:

"The Executive Staff appointed Dr. Duehring to represent the Georgetown University Hospital in an informal capacity at the Group Health Association meeting with the following instructions, which he is at liberty to use or ignore.

"1. The Georgetown University Hospital will grant privileges to practice to any doctor whose qualifications are such as are deemed sufficient by the credentials committee of the hospital to practice his specialty.

"2. Any patient who is a member of the Group Health Association applying to the Georgetown University Hospital for treatment of any nature will be admitted to the hospital and cared for by the doctor of his choice if said doctor is a member of the staff, or by a designated member of the staff.

"This was seconded and adopted.

"Dr. Duehring said he believed the group should be informed that the hospitals of this city are more open than hospitals in the New England States which are closed to all except those on the staff.

"Dr. Koppanyi said we should tell them frankly that hospitals cannot be coerced into taking men that were not qualified.

"Dr. Martel said that Dr. Scandifio is qualified. He has done something we do not approve and that probably that is what they would like to have some one say. Dr. Martel felt that we should not send a representative.

"Dr. Cahill said we could not ignore the letter. Providence Hospital is sending representative. Thought sending a letter would be better explaining we will be glad to take patients but men must be approved.

"Dr. Duehring moved that a representative be sent to speak informally. Seconded by Dr. Mollari.

"Dr. Coe thought that speaker might refer to the compensation commission work and suggest that the Group Health Organization, Inc. workings might be run along the same lines.

"Father McCauley asked Dr. Martel to go as representative but he declined for reasons of his own. Dr. Duehring was asked to go and accepted.

"Sister Rodriguez felt that a letter should be taken along with definite statements to be read.

"Dr. Vaughan thought that a letter should be taken and used if necessary.

"This was finally done.

"Moved to adjourn at 12:30 p. m.

"V. J. Dardinski, M.D., Secretary.

TESTIMONY OF R. STEPHEN HULBURT

DIRECT EXAMINATION

By Mr. Kellcher:

Richard Stephen Hulburt said he is a general practitioner, a graduate of Georgetown University in 1931.

Q.—And while you were in private practice were you associated with Georgetown University Hospital?

A.—Yes.

Q.—In what capacity?

A.—I was Clinical Instructor in Medicine in the Out Patient Department, that is the Dispensary.

Q.—And how long were you Clinical Instructor in that Out Patient Department?

A.—From about 1932 until about 1937.

Q.—What were your duties as Clinical Instructor?

A.—They were to take care of medical patients in the dispensary and to advise students there in their work.

Q.—Did you also at the same time have courtesy privileges at that hospital, that is, the privilege of bringing in your own patients and treating them there?

A.—I think I did.

Q.—Did you have that continually from the time you finished your internship until 1937?

A.—I don't believe I applied in a formal application immediately; it must have been, maybe, as much as two years before they requested me to fill out a formal application blank.

Q.—Would that be about 1935?

A.—Yes.

Q.—And did you fill out a formal application blank about that time?

A.—Yes.

Q.—And were you formally notified that you had such privileges at the Georgetown Hospital?

A.—Yes.

Q.—What privileges did you have?
A.—Privileges for general medicine; normal obstetrics and minor surgery.
Q.—Dr. Hulburt, did you join the staff of Group Health Association in 1937?
A.—I did.
Q.—Did you join as an assistant to Dr. Lee?
A.—That was the understanding.
Q.—Were you with Group Health Association at the time the clinic opened, their clinic?
A.—I was.
Q.—Who was Gretchen Moriarity?
A.—Gretchen Moriarity was one of the members of Group Health who came there as a prenatal case.
Q.—Did you handle her case early in 1938?
A.—I did.
Q.—Will you tell us what occurred on April 7, 1938, with respect to her case?
A.—I believe she phoned me at the clinic some time in the morning and said she—
Mr. Leahy:—I object to the conversation.
THE COURT:—Sustained.
By Mr. Kelleher:
Q.—Did you attend Mrs. Moriarity?
A.—I did.
Q.—In what condition did you find her?
A.—You mean in the clinic?
Q.—No, on April 7.
A.—I visited her at Georgetown Hospital and she was in labor and I gave her the necessary examination and went back to the clinic.
Q.—After she called you, did you call Georgetown University Hospital?
A.—Yes.
Q.—And whom did you talk to at the Hospital?
A.—I asked for the admitting office and talked with the girl in the office.
Q.—And did you ask permission to bring Mrs. Moriarity in?
A.—I did.
Q.—And what did the admitting office say?
Mr. Leahy:—I objected to that; it is hearsay.
Mr. Lewin:—Falls under the same ruling your Honor has made.
Mr. Kelleher:—I will also connect it up with the Superintendent.
Q.—Did you speak directly with the admitting office: Did you ask for the admiting office?
A.—I asked for the admitting office, and I believe I was connected with it.
THE COURT:—While you were connected with the hospital you talked on the phone?
The Witness:—Yes.
THE COURT:—Overruled.
The Witness:—I talked with the girl in the office and told her I was Dr. Hulburt, connected with Group Health, and I had this obstetrics case in active labor. I would like to have her admitted as an obstetrics case; she needed hospitalization.
Q.—And what did the clerk in the admitting office say?
A.—She said she didn't know whether there was any vacancy, but she would find out, and I think she inquired of Sister James Joseph.
Q.—And who was Sister James Joseph?
A.—She was the Sister in charge of the office.
Q.—What was the conversation you had with her?
Mr. Leahy:—The same objection.
THE COURT:—Overruled.
A.—I asked her to admit this patient. I told her I wanted her to admit this patient; that she had a history of having previous children who were delivered very quickly, and her membranes were already ruptured, and I thought she should be in the hospiatl where she could be under observation.
Q.—And what did Sister Joseph say?
A.—She just asked me to wait a minute; she would take it up with Sister Rodriguez.
Q.—Did she make any suggestion as to who should handle Mrs. Moriarity in the hospital if she was admitted?
A.—I don't recall.
Q.—Did she say anything about the patient being treated as a house patient?
A.—She may have; I don't recall that especially; she may have said that.
Q.—What is a house patient?
A.—A patient who comes in and who is under the treatment of the physician in charge of that service in the hospital.
Q.—I believe you already testified that she said she would speak to Sister Rodriguez?
A.—Yes.
Q.—Who is Sister Rodriguez?
A.—She was the Superintendent of the Hospital at that time.
Q.—Did you wait at the phone while she did that?
A.—I did.
Q.—And did Sister Joseph return to the phone?
A.—Yes.
Q.—What did she say at that time?
A.—She said, Sister Rodriguez said it would be all right to admit her as an emergency patient; that they would never turn down any case that needed help.
Q.—Did you send Mrs. Moriarity in to the hospital?
A.—I did.
Q.—And you attended the patient in the delivery room at that hospital?
A.—You mean in the actual delivery room? I was in and I saw her in the first stage room.
Q.—Did a nurse approach you there at that time?
Mr. Richardson:—I suggest that the witness tell this without the leading questions.
THE COURT:—Yes.
By Mr. Kelleher:
Q.—Will you tell the jury what occurred there at that time?
A.—I went over there about 1 o'clock, I guess, in the afternoon, and examined her, and found that she was not having any pain, and that the procedure of the labor was not as fast as I anticipated, but I knew from her history she had a very rapid labor in other cases. In fact she had no other pains at all. So I examined her and went back to the clinic, and about 5 o'clock, while I was in the clinic, I received a phone call to come to Georgetown right away; that the patient was ready to be delivered. I started out but at that time of day the traffic was heavy. I didn't get here until 5:30. When I got there the nurse told me that Mrs. Moriarity had a sudden pain and the baby had been delivered without any pain. I examined her and found she was all right. The nurse then said that Sister Rodriguez wished to speak with me, so I waited in the doctors' room, the delivery room, and she told me she was glad to admit the patient as an emergency case, and that they would never think of not allowing any one to come into that hospital who they thought could be helped there, but that I should realize that I no longer had privileges there. I said I didn't know that; I had not been notified to that effect, but I didn't care to argue or remonstrate, so I told her I was sorry and went on.
Q.—When did you resign from Group Health Association?
A.—On April 25, 1938.
Q.—After you had resigned from Group Health, did you have a conversation with Sister Rodriguez about obtaining courtesy staff privileges from the hospital?
A.—I did.
Q.—And did you make formal application for such privileges?
A.—Yes.
Q.—Were those privileges granted to you?
A.—Yes.
Q.—Do you have a formal letter notifying you that such privileges had been granted?
A.—I do.
Q.—May I have it? I show you Exhibit 530 and ask you whether that is the letter you received after you applied for courtesy privileges at Georgetown Hospital, after your resignation from Group Health?
A.—It is.
Mr. Kelleher:—I offer Exhibit 530 in evidence.
Mr. Leahy:—No special objection.

U. S. EXHIBIT 530

Mr. Kelleher:—Exhibit 530 is dated May 12, 1938:

"My Dear Dr. Hulburt:

"Your application to practice at the Georgetown University has been approved by the Credentials Committee.

"You have been granted privileges to practice in the branches of medicine checked herein with the understanding that you become a member of your own local medical society within the year."

And there is a check mark next to "Minor surgery," "Medicine," and "Obstetrics, normal."

"Very sincerely yours,
"SISTER MARY RODRIGUEZ
"Superintendent."

By Mr. Kelleher:
Q.—Dr. Hulburt, while you were connected with the staff of Group Health did you apply for privileges at Columbia Hospital?
A.—I don't recall, while I was with Group Health.

Q.—Did you have privileges at Columbia while you were with Group Health?

A.—I don't believe I did.

Q.—Did you obtain privileges at Columbia after you resigned from Group Health?

A.—Yes, I did.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Doctor, do you recall now whether you had ever made application for privileges at Columbia Hospital before you went with Group Health?

A.—I don't recall.

Q.—Isn't it a fact that with any of the hospitals in Washington you have to make application for such privileges?

A.—Yes, that is the general procedure.

Q.—And you have no recollection now of ever having made such an application to Columbia while you were with Group Health, or before you were with Group Health?

A.—No.

Q.—And when you did make application you followed the general routine required by applicant for such privileges in the local hospitals?

A.—When I did apply?

Q.—Yes?

A.—Yes.

Q.—And when you so applied you received it?

A.—Yes.

Q.—Do you remember what year you made the application and received the privileges?

A.—I think 1938.

Q.—After you had resigned from Group Health?

A.—Yes.

Q.—And when was it you resigned from Group Health?

A.—April 25, 1938, I think.

Q.—And how long were you with the G. H. A.?

A.—Just a little over five months.

Q.—And what time did you serve with G. H. A. during that period; was it part time or full time?

A.—I understood it was to be part time, but before I had been there very long it developed into full time.

Q.—What was the reason for that?

A.—The demand was great. There was just so much work, there wasn't any time to do anything else. I did the clinic hours from 9 to 1, made the calls from 1 to 3 and from 3 to 6 was in the clinic.

Q.—When you first went to the clinic what was your time to be?

A.—That was an understanding with Dr. Lee, who first interested me. I understood I was going in to help him as a sort of his assistant in internal medicine.

Q.—Before you got through, you were doing other things?

A.—Yes, I was doing other things. The pressure of the work was so great, so varied, I was doing a great many things.

Q.—You say the pressure of the work was so great and so varied—

Mr. Kelleher:—We object to this line of testimony. It is not proper cross examination. We did not go into that.

THE COURT:—Objection sustained.

By Mr. Leahy:

Q.—At the time you went into the Group Health work, did you go into it for any definite period?

Mr. Kelleher:—Same objection.

Mr. Leahy:—You asked him about his resignation.

Mr. Kelleher:—I didn't ask him about his reasons at all.

THE COURT:—The cross examination is limited, of course.

Mr. Leahy:—Does your Honor hold that I should not go into the reason why he resigned?

THE COURT:—I don't think it is material.

Mr. Leahy:—May I approach the bench?

THE COURT:—Yes, you may have some reason that I can't think of.

Mr. Leahy:—If I have, I assume your Honor will admit the evidence.

(Counsel for both sides approached the bench.)

By Mr. Leahy:

Q.—Now, Doctor, will you tell us why you resigned in April 1938 from Group Health?

A.—Well, I resigned for many reasons that had been going over in my mind for many months, before I made my decision. I had gone to Group Health with the idea: I had heard Dr. Lee describe it as going into a new organization which would provide better medical practice, and it would build up to be comparable to the Ross-Loos Clinic in Los Angeles, and, perhaps, even the Mayo Clinic. That I would go in as an assistant and be associated with men of national reputation, and I thought it would be of professional advantage to do that. I went in on that basis. For the first month it worked very well. There weren't so many people coming in. By the middle of December the volume worked up, the volume of work had become so great that I was doing work from early morning until late at night—full time work and over.

THE COURT:—I think that is too long; I don't want him to review his relationship with Group Health.

By Mr. Leahy:

Q.—I will ask you if the reason why you left the Group Health Clinic was not because from your experience with the Clinic you found you couldn't do good medical service because of the stress of work laid on you?

Mr. Kelleher:—Objected to; not proper cross examination.

THE COURT:—The Doctor can answer that question yes or no, and it excludes all his explanation as to his relationship with the Group Health; I think he may answer that.

The Witness:—Will you read the question?

Mr. Leahy:—Was it the reason you resigned from the Group Health Clinic in April 1938, that after your experience with it for five months you found you couldn't do good medical work in the clinic because of the stress of work laid on you?

A.—Yes.

RE-DIRECT EXAMINATION

By Mr. Kelleher:

Q.—Didn't you come with Group Health with the understanding you would be Dr. Lee's assistant?

A.—Yes, to help him in medical work.

Q.—And what happened to Dr. Lee?

A.—He left.

Q.—Resigned from Group Health?

A.—Yes.

Q.—In December 1937?

A.—I guess it was about that time.

Q.—And was it then that the work of the Clinic increased and your duties increased?

A.—It was before the middle of December.

Q.—Did your duties increase after Dr. Lee resigned?

A.—They were increasing every day; even before he resigned.

Q.—Were they substantially increased after he resigned?

A.—Yes.

Q.—And were they heavy during the period between the time when Dr. Lee resigned and Group Health obtained Dr. Price?

A.—Yes.

Q.—Did the fact that you were excluded from Georgetown University Hospital influence you in your decision to resign from Group Health?

A.—No, not materially at all.

Q.—Did it influence you at all?

A.—It didn't influence me, it influenced my wife.

Q.—It influenced your wife?

A.—Yes.

Q.—Did you discuss this with your wife?

A.—Yes.

THE COURT:—I don't think it is necessary to go into that.

By Mr. Kelleher:

Q.—Are you a member of the Medical Society now?

A.—I am.

Q.—When did you join?

A.—I filed my application, I think, the following summer after I resigned from Group Health, and at the first meeting after that they acted on it; in November, I think it was, I was accepted in November 1938.

Q.—Prior to your resignation from G. H. A. did you have a discussion with the defendant Yater?

A.—I did.

Q.—What was the substance of that discussion?

Mr. Leahy:—I object to that.

THE COURT:—It is not re-direct examination.

Mr. Kelleher:—It bears directly on the question of why he resigned from Group Health.

THE COURT:—Are you cross examining him?

Mr. Kelleher:—No, this is re-direct examination.

THE COURT:—Well, still he is your witness. You can't cross examine him. If the question refers to anything he might have said to Dr. Yater, it would be a matter of impeaching your own witness, and I don't think you want to do that.

Mr. Kelleher:—I want to show what Dr. Yater said to him.

THE COURT:—You might ask him if Dr. Yater persuaded him in any way to resign, and if he says yes there might be something in that.

Mr. Kelleher:—I think I will let it go.
Mr. Kelleher:—May I recall the witness? I am very sorry.
THE COURT:—Yes.
By Mr. Kelleher:
Q.—Dr. Hulburt, on cross examination you testified that you could not recall whether you had applied for privileges at Columbia Hospital while you were a member of Group Health?
A.—Yes.
Q.—I now show you Government Exhibit 509, which is in evidence, and will read you this to see if it will refresh your recollection.
Mr. Leahy:—Just a minute. Let him see it.
Mr. Kelleher:—I am going to read it.
Mr. Leahy:—No you are not; you should show it to the witness.
Mr. Kelleher:—In order for the situation to be clear, I will read it to the jury:

U. S. EXHIBIT 509

"The application of R. Stephen Hulburt for privileges was tabled."

This is the minutes of the Medical Board. Now does that refresh you as to whether you applied for privileges at Columbia Hospital during the period while you were with the G. H. A.?
A.—No, sir.
Mr. Kelleher:—No further questions.
I now would like to read from Exhibit 510, the minutes of the meeting of June 9, 1938, of the Board of Columbia Hospital.

U. S. EXHIBIT 510

"The following applications for courtesy privileges were considered. "R. Stephen Hulburt was approved."

TESTIMONY OF FRANCIS X. RICHARDSON

DIRECT EXAMINATION

By Mr. Lewin:

Francis X. Richardson said he was licensed to practice medicine in the District of Columbia in 1938. He graduated from George Washington University and interned at Providence Hospital.

In 1937 and 1938 he lived at 118 Carroll Avenue, Takoma Park, Maryland. He was then a member of the American Medical Association's constituent Society in Maryland. He joined the medical staff of the Group Health some time in December, 1937.

Q.—Did you apply for the appointment?
A.—No, sir. I applied for the appointment in that a man asked me if I would be available for outside calls and I told him I thought I would, and I did go and see about it.
Q.—Who was the man who suggested that?
A.—George McDuffy.
Q.—After Mr. McDuffy asked you whether you would be available, did you then go down to the Group Health Clinic and apply for the work?
A.—I went to see Dr. Brown, who was the Medical Director.
Q.—And as a result of that conversation did you join the staff?
A.—For outside calls, yes.
Q.—Now, what kind of a doctor are you? Have you any specialty?
A.—No.
Q.—Would you be known as a general medicine man?
A.—General practitioner.
Q.—You are not a surgeon?
A.—I am not.
Q.—What services did you undertake to perform for Group Health?
A.—My contract with them was to take outside calls when they called at my office, and make visits to homes.
Q.—Was it intended to be full time, or were you permitted to practice on the side?
A.—It was part time; I was to be permitted to practice in addition.
Q.—And what was the arrangement as to your compensation, at first?
A.—The arrangement was that I should receive a salary of $150 for making the outside calls, and 4 cents a mile for mileage.
Q.—$150 per what period of time; per month?
A.—Yes.
Q.—You were to get $150 and 4 cents a mile for transportation?
A.—Yes.
Q.—Now did you enter into the performance of these services?
A.—Yes, I did.
Q.—How long did you continue with Group Health on that basis?
A.—I resigned from Group Health on the 15th day of July, 1938.
Q.—That is a little over six months after you joined the staff?
A.—Yes.
Q.—Before you resigned had there been any change in the basis of your compensation?
A.—Originally I was only to take calls in and around Takoma Park, and I then took some calls in the District when they raised the compensation to $200 a month.
Q.—You resigned July 15, 1938?
A.—Yes.
Q.—Did you have a conversation with two members of the defendant, District Medical Committee, on that day at the Sibley Memorial Hospital?
A.—I don't know whether those men were members of the Medical Society or not. I had a conversation with Dr. McNulty and Dr. Mann.
Q.—What are Dr. McNulty's initials?
A.—I am not positive.
Q.—Were those men friends of yours, close friends?
A.—I know Dr. McNulty pretty well. I had known him while I was an intern.
Q.—You don't know his initials?
A.—No.
Q.—Do you know Dr. Mann's initials; Jesse Mann?
A.—I know it is Jesse Mann.
Q.—Where did you have the conversation?
A.—In the cloak room at the Sibley Hospital.
Q.—Did you have courtesy staff privileges at Sibley?
A.—Yes.
Q.—At the time?
A.—Yes.
Q.—All through the 1937 and 1938?
A.—Ever since I began practicing medicine.
Q.—And at other hospitals?
A.—Garfield and Providence.
Q.—Did you have them during that seven months period in 1938?
A.—Yes.
Q.—Now, how did the conversation with Dr. McNulty and Dr. Mann begin? Did they start the conversation or did you?
A.—Dr. McNulty asked me—
Mr. Leahy.—I object to the conversation; it is pure hearsay; the answer is not responsive.
THE COURT.—He didn't ask you that.
The Witness.—Dr. McNulty.
By Mr. Lewin:
Q.—Had you been attending a patient at Sibley at the time the conversation began?
A.—I had; I had been; I was leaving and getting my hat at the cloak room.
Q.—Had you been attending a Group Health patient at Sibley, or a private patient at Sibley?
A.—A private patient; I never had any Group Health patients at any hospital.
Q.—You are not a surgeon?
A.—I never had anything to do with a case requiring hospitalization for a Group Health patient.
Q.—Were Drs. Mann and McNulty together when you had this conversation with them?
A.—Yes.
Q.—Now will you tell the jury. Give your best recollection of the substance of what they said to you.
Mr. Leahy.—Objected to as hearsay.
Mr. Lewin.—It is already in evidence that Dr. McNulty was a member of the District Medical Society, and had been attending some of the meetings. That appears from the minutes which are here and which have been read. It is also in evidence that Dr. Mann was on the Hospital Committee of the Medical Society, which committee was under the chairmanship of Dr. Warfield; and your Honor will also recall from the evidence the activities of that committee. With that evidence in the record I ask that I be permitted to have the statements made at that time to this witness.

THE COURT.—I doubt very much if it is competent evidence. Will you step up here?

(Thereupon counsel approached the bench.)

FEBRUARY 28—MORNING

TESTIMONY OF DR. FRANCIS X. RICHARDSON (RESUMED)

DIRECT EXAMINATION (RESUMED)

By Mr. Lewin:

The witness was asked to identify the letter sent on July 15, 1938, to the Medical Director of Group Health Association.

Mr. Leahy:—That is objected to, if your Honor please, entirely immaterial; the witness is here.

(Mr. Lewin handed document to THE COURT.)

THE COURT:—Step up here a minute.

(Counsel for both sides approached the bench.)

By Mr. Lewin:

Q.—Now, did you write and send in this letter, Exhibit 531, after you had this talk in the cloakroom in the Sibley Hospital with Drs. Mann and McNulty? *A.*—Yes.

Mr. Lewin:—Exhibit 531 is Dr. Richardson's resignation. It is on his letterhead. It is addressed to R. G. Selders, the Medical Director of G. H. A., and reads:

"Dear Dr. Selders:

"This is to advise you that upon receiving this letter I shall be no longer available to accept calls for Group Health Association.

"Sincerely yours,
"Francis X. Richardson, M.D."

By Mr. Lewin:

Q.—Now, without telling us what was said at that conversation let me ask you whether there was any connection between that conversation and this resignation.

Mr. Leahy:—Objected to.

THE COURT:—Sustained.

By Mr. Lewin:

Q.—Without telling us what the conversation was at the Sibley Hospital, tell us why on July 15, you sent in this resignation.

Mr. Leahy:—Same objection.

THE COURT:—Sustained.

Mr. Lewin:—Will you hear me on this? It is clearly under the allegation of the indictment.

THE COURT:—The only effect would be to get in indirectly what I have ruled out directly.

Mr. Lewin:—I thought you ruled it out as hearsay.

THE COURT:—It is an attempt to get into this case hearsay.

Mr. Lewin:—The indictment alleges he resigned for a certain reason. I should like to show that reason.

THE COURT:—You have told me that. I have ruled.

Mr. Lewin:—I can't go any further; I hand him over to you.

CROSS EXAMINATION

By Mr. Leahy:

. . . . . .

Q.—And you had your own office from 1934 to 1937?

A.—Yes.

Q.—And you went in with Group Health as a part-time man, did you? *A.*—Yes.

Q.—What time: when did your hours begin? *A.*—It began in the morning any time, about ten-thirty, as a rule, I used to get the first call.

Q.—And ran on all through the day and night? *A.*—It ran up to night, yes.

Q.—How late at night? *A.*—Very seldom did I have to make calls after 8:00 o'clock at night.

Q.—Have you any idea how many calls a day you made?

Mr. Lewin:—Objected to as immaterial.

THE COURT:—Sustained.

Mr. Leahy:—Could I ask your Honor to approach the bench?

THE COURT:—Yes.

(Counsel for both sides approached the bench.)

By Mr. Leahy:

Q.—You were first employed at the rate of $150 per month? *A.*—Yes.

Q.—The Group Health Association paid you, did it? *A.*—Yes.

Q.—And later on it was increased to $200 a month? *A.*—Yes.

Q.—Do you remember when it was raised to $200?

Mr. Lewin:—Objected to. Not proper cross examination.

THE COURT:—It was brought out on direct. He may answer.

The Witness:—Some time in February.

TESTIMONY OF WILLIAM C. KIRKPATRICK

Recalled as a witness.

FURTHER DIRECT EXAMINATION

By Mr. Lewin:

Q.—Mr. Kirkpatrick, I would like to ask you whether you know how final payment was made for hospitalization bills at the Sibley Hospital, bills of Tommilee Nix; Howard Vickery, and Miss Taylor Owen. *A.*—Yes, I know.

Q.—How was it done? *A.*—Made in cash.

Q.—By whom? *A.*—Well, I had the cash drawn and in one instance I gave it to my secretary to take up there; and in another instance I gave it to one of the patients, and in the third instance our bookkeeper took it up, Mr. Bias.

Q.—And the money came from the treasury of Group Health Association? *A.*—Yes, we drew the money from the bank. We didn't receive receipts for that money, as an association.

Q.—Did you have any instances in which Group Health Association compensated members of the District Medical Society for services rendered to Group Health patients? *A.*—Yes, I recall a few instances of that sort.

Q.—Were there any cases in which it was necessary to pay in cash? *A.*—Yes, I think Dr. Warfield was one instance.

. . . . . .

Q.—Now, what was your purpose in seeking this interview with Mr. Rice of the Washington Sanitarium? *A.*—Our purpose was this. We hadn't succeeded at that time in getting our doctors into the hospitals in Washington so we thought we would try the Washington Sanitarium, and for that purpose we went to see Mr. Rice.

Q.—What did you say to Mr. Rice on that occasion, and what did he reply? *A.*—I told Mr. Rice—

Mr. Leahy (interposing):—Who is he, Mr. Rice?

The Witness:—Credit manager of the Washington Sanitarium.

Mr. Leahy:—I object to the conversation with Mr. Rice.

THE COURT:—The position of credit manager doesn't indicate any general power on the part of such a person to bind the hospital.

Mr. Lewin:—Your Honor has already admitted Exhibit 451, which is Mr. Kirkpatrick's letter to Mr. Rice.

THE COURT:—Yes, I did that in the belief, on the theory that in the natural course of things a letter sent would get to the proper official of the hospital. When you ask for a conversation had with a credit manager, that is something else. There does not appear any inherent power in such a person to speak for the corporation.

By Mr. Lewin:

Q.—How did you make your approach to the Washington Sanitarium; had you known Mr. Rice previously? *A.*—No, we went out there and asked for the man in charge and were directed to Mr. Rice.

Q.—You asked for the man in charge of the hospital? *A.*—Yes.

Q.—Who did you ask that of? *A.*—The information desk.

Q.—And you were directed to Mr. Rice? *A.*—Yes.

Q.—Did he have an office there? *A.*—He did.

Mr. Lewin:—What do you think of it now, your Honor?

THE COURT:—I don't think that helps any. I don't know who directed him. It may have been an elevator boy.

The Witness:—No, it was a lady seated behind a desk marked "Information."

Mr. Lewin:—I don't know how a person would go about reaching the proper official. He said he went out there and went through the main door to this information desk and was referred to Mr. Rice.

The Witness:—The only door I saw, I guess it was the main door.

By Mr. Lewin:

Q.—And there was a desk there with the word "Information" on it? *A.*—Yes, there was a desk with "Information" on it, and I asked who was in charge of this hospital and they directed me to Mr. Rice.

Mr. Lewin:—I submit, your Honor, we are in the right pew. I don't know where else anybody would go except to the reception desk.

Mr. Leahy:—Aren't there some exhibits in the case?

Mr. Lewin:—Indeed there are. An exhibit which has been admitted which shows Mr. Kirkpatrick's letter to Mr. Rice. Now, it must have gotten into the proper channels because he gets this reply from Dr. Hare.

THE COURT:—I have no doubt about that. It bears out exactly what I said. You haven't proved Mr. Rice's authority to act for the hospital. If you can show me where it is I will be glad to see it.

Mr. Lewin:—Your Honor's ruling is that I can't go into that conversation; either bring out what Kirkpatrick told the hospital or what was said to him?

THE COURT:—Yes.

(The witness was then taken up to the conference with Major Gist Blair.)

The Witness:—We met in the office of Major Blair in the Emergency Hospital. Present at that conference was Major Blair, Mr. Sandidge, the superintendent of the hospital, and Dr. Mitchell, who, as I understood, was chief of the surgical staff. Accompanying me was Mr. Horace Russell, a member of the Board of Directors and General Counsel for the Federal Home Loan Bank Board. We stated the purpose of our visit there, namely to see whether we could enter into an arrangement whereby doctors of Group Health could make application to Emergency Hospital and be admitted to courtesy privileges, provided their qualifications were proper.

We found Major Blair very cooperative. He made the statement that he was in sympathy with what we were trying to do, and he made the statement that he thought there was a place in the medical field for Group practice of medicine.

Mr. Sandidge contributed nothing to the meeting. He didn't say a word. Dr. Mitchell said very little more. After some discussion of perhaps 20 minutes or a half an hour, they spoke of getting our staff in there. Major Blair volunteered that he would do what he could among his acquaintances in the other hospitals and among the medical fraternity in the District to see whether or not this question might not be resolved in favor of Group Health to the end that we be admitted to that hospital, but he offered the information that it was a part of the by-laws of that hospital that any physician on the courtesy staff must by reason of that fact be a member of the District Medical Committee, and we told Mr. Blair that none of our doctors at that time were such. He said that he would communicate with us in writing when and if he was successful in obtaining any information that he thought might be helpful or favorable to us, and at the end expressed his interest in this thing and his sympathy with it, and with that the meeting ended.

Q.—Were you asking for the admission of any particular doctor on Group Health staff or all the doctors? *A.*—We didn't name anybody at all. We asked for the staff as a whole. We said "our doctors." That is the way we put it.

(The witness identified some of the correspondence.)

Mr. Lewin:—I am going to offer in evidence Exhibit 392, which is a copy of a letter to Major Blair from Mr. Horace Russell, and Major Blair's reply, which is Exhibit 532, to Mr. Horace Russell, dated Feb. 10, 1938. I call counsel's attention to the fact that apparently that letter of Major Blair is not signed by him. It has been testified that the initials "C. G." which appear on it are the initials of his secretary or assistant secretary.

Mr. Richardson:—May we approach the bench?

THE COURT:—Yes.

(Counsel for both sides approached the bench.)

U. S. EXHIBIT 392

Mr. Lewin:—Government Exhibit 392 is a letter from Mr. Horace Russell to Major Gist Blair, dated February 9, 1938, reading as follows:

"Dear Major Blair:

"I write to express my appreciation and that of my associates for your accommodation of us in arranging for and taking the time to discuss with Mr. Kirkpatrick and me the hospitalization problems of the members of Group Health Association, Incorporated. We were glad to present to you and your associates at the hospital our problem as best we could and, particularly, we appreciate your kindness in suggesting that you would look further into the matter and discuss it with others and see what can be done about it.

"It occurred to me that you might like to know that in our recent dealings with the Medical Society of the District of Columbia it has been represented by Messrs. Frederick A. Fenning, George P. Hoover and Wm. E. Leahy, and it may be that you will be willing to discuss the matter with these gentlemen. We assure you that we shall be glad to discuss this problem with you and others concerned at any reasonable time, and that we are anxious to make proper provision for our hospitalization which will permit our treatment in the hospitals by competent physicians and surgeons selected by ourselves. We should like very much to avoid any controversy about the matter if we can.

"Meanwhile, we shall await word from you as to the course you advise.

"Very truly yours,

"Horace Russell."

Mr. Magee:—Read the next line.

Mr. Lewin:—"Horace Russell, General Counsel."

I will read the next one, which is dated Feb. 10, 1938, from Gist Blair to Horace Russell:

U. S. EXHIBIT 532

"Dear Mr. Russell:

"Replying to your letter of February 9th, I think I understand your method of approaching the hospitalization problems of the members of the Group Health Association, Inc. and for that reason I feel I can say that I try to approach problems in this same way. The problem you have suggested to me is a very big one and the adjustment of the conflicting interests requires tact and persistence and a great deal of trouble to instill into the minds of people whose interests are affected a comprehension of the wisdom necessary to give up a little on their part in consideration of a little being given up on the part of others.

"I am not able to clear up your problem for you much as I would like to do so. I will, however, feel around and find just what can be done and if I find any favorable indications, I will arrange a meeting with you. I do not like letter writing because letter writing sometimes adds to the many misunderstandings which angry discussion always causes and frequently brings about the worst possible results.

"Sincerely yours,

"Gist Blair."

By Mr. Lewin:

Q.—I think you have told us that following some correspondence with Mr. Aspinwall, the president of Garfield Hospital, you had an interview with him in February of 1938? *A.*—That is correct.

Q.—Will you state to the jury the substance of that conversation? *A.*—Present there were Mr. Aspinwall, Mr. Ormond Loomis Reed and myself. I told Mr. Aspinwall the purpose of our visit, which was to try to get the members of our staff admitted to the courtesy staff of Garfield Hospital. He knew that Dr. Selders had already had temporary privileges there; but I told him that we were interested not only in one physician, but we were interested in all of them. I asked what he thought he could do to bring about that result. "Well," he said, "I have been following the difficulties that you seem to be having for some time past here and," he said, "I am not altogether in sympathy with some of the opposition that you encounter." He said, "We in the hospital board of trustees are, for the most part, laymen, and we try to be guided in our decisions with respect to the admission of physicians by the conclusions of the medical staff who, in the end, are the ones we deem best fitted to advise us."

He offered also to speak among his friends in the other hospitals and among the physicians here in Washington and see if some solution of this question might not be had. He made this suggestion, that what he called a Committee of Arbitration be established to the end that both sides might submit whatever they chose to that committee, and ask the committee to arrive at a conclusion. That conclusion would be adhered to by agreement of both sides. Nothing ever came of the suggestion, so far as I know. I never heard anything more about it.

During the course of the conversation I told Mr. Aspinwall that word had come to me that the physicians of at least one hospital in Washington, which perhaps was his, had threatened to walk out if any member of the staff of Group Health Association were admitted to that hospital.

"Well," he says, "I am afraid of that."

"Well," I said, "Mr. Aspinwall, when are the trustees of these hospitals, who certainly have a trust to perform, going to take this question in hand and make some decision about it?"

"Well," he says, "I don't know." He says, "We are pretty much in the hands of the physicians in our hospitals."

He volunteered to ask his counsel, Mr. ——— I have forgotten the name of the gentleman—

Q.—Mr. Dunlop?

A.—Mr. Dunlop—to confer with counsel for Group Health Association, just as a matter of clearing up any question of legality that might be in Mr. Dunlop's mind. No question of the legality of the Association was brought up at that meeting at all. It all hinged on the question of admission of the doctors of our staff as such to the courtesy staff of the hospital.

Q.—Did you hear anything further from Mr. Aspinwall except the letters that we offered in evidence on the day you were on the stand? *A.*—No, sir; that is the last I had from Mr. Aspinwall.

Q.—Following your correspondence, or your letter of July 28, telling him about Mr. Justice Bailey's decision? *A.*—That is right, sir.

Q.—Do you know Mrs. Eugene Meyer? *A.*—I do.

Q.—Is her name Agnes E. Meyer? *A.*—That is what I understand.

Q.—Who is she? *A.*—She is the wife of the owner and publisher of The Washington *Post*.

Q.—Did you ask her to do anything for Group Health Association in the way of getting in any of the hospitals?

Mr. Leahy:—Objected to as immaterial.

THE COURT:—I do not see the admissibility of it on the face of the question.

Mr. Lewin:—May we come to the bench, your Honor?

The Court:—Yes. I would like to know what the purpose of the question is.

(Counsel for the respective parties approached the bench.)

By Mr. Lewin:

Q.—I believe you are permitted to answer that last question.

The Court:—I think you asked him if she did write a letter.

Mr. Lewin:—I do not think that is clear in the record, your Honor.

By Mr. Lewin:

Q.—Did you ask Mrs. Meyer to write to one of the Washington hospitals?

Mr. Leahy:—I object to that as immaterial. Let him identify the letters if he can.

Mr. Lewin:—His Honor thought it was already it, and I was just trying to clear up the question.

The Court:—He may answer the question.

Mr. Richardson:—Do I understand you include the text of the letter, the argument that is made in the letter that went to the hospital?

The Court:—I do not know whether there was an argument or not. I have not seen the letter. Some of it may not be admissible; I do not know. But I am permitting these preliminary questions.

By Mr. Lewin:

Q.—What is your answer? *A.*—I asked Mrs. Meyer—

Mr. Leahy:—Yes or no; that is enough.

The Court:—Yes.

The Witness:—Yes.

By Mr. Lewin:

Q.—Now, tell us what you asked her to do.

The Court:—I do not think you need to go into the details of it.

By Mr. Lewin:

Q.—What hospital did you ask her to approach? *A.*—The Casualty Hospital.

Q.—Did she agree to do it? *A.*—She did.

Mr. Leahy:—I object.

By Mr. Lewin:

Q.—What did she tell you she would do?

Mr. Leahy:—I object.

The Court:—Objection sustained. I am not going into the details of that conversation. I think there is enough of it which is preliminary to the letter.

By Mr. Lewin:

Q.—At your request did she write a letter to Mr. Allmond, the secretary of the board of trustees of Casualty Hospital?

Mr. Leahy:—I object. He cannot know whether she wrote a letter except just by hearsay.

The Court:—He might know if he saw her write it. He can say whether he knows.

The Witness:—She did.

By Mr. Lewin:

Q.—Did she show you the letter she sent them? *A.*—She did.

Q.—Is this (indicating) the letter she sent Mr. Allmond of the Casualty Hospital? *A.*—That is the letter; yes, sir.

Q.—Did she show you the reply that she received? *A.*—She sent me the reply.

Q.—I show you U. S. Exhibit 534, which purports to be her letter to you, dated June 11, 1938, and ask you if that is the letter she sent you? *A.*—It is.

Q.—And I will show you U. S. Exhibit 536 and ask you if that was the letter from Casualty Hospital which she enclosed? *A.*—It was—it is, rather.

Mr. Lewin:—I offer them in evidence.

Mr. Leahy:—May I pass these to the court?

The Court:—Yes.

Mr. Lewin:—Do you object to them?

Mr. Leahy:—Yes, indeed (handing letters to the court.)

(Counsel approached the bench.)

. . . . . .

Mr. Lewin:—Members of the jury, the court rules that U. S. Exhibit 533 for identification, Mrs. Meyer's letter, is not admissible, but I am permitted to state that that letter did request from that hospital the admission of Group Health Association doctors for courtesy privileges.

Exhibit 536, however, is received in evidence, and it is the reply of S. H. Rogers, president of the board of directors of the Eastern Dispensary and Casualty Hospital, to the letter of Mrs. Meyer, dated June 10, 1938, and on the letterhead of that hospital:

U. S. EXHIBIT 536

"Mrs. Eugene Meyer
1624 Crescent Place N.W.
Washington, D. C.

"Dear Mrs. Meyer:

"I wish to acknowledge your letter of the 26th to Mr. Allmond, the Secretary of our Board, on the subject of Hospitalization for Group Health Association Patients, as I am Chairman of the Committee which has handled this problem for our Board.

"Our Committee has given very earnest consideration to this problem as relates to our institution, but as stated to Mr. Kirkpatrick and Mr. Loomis at a recent interview, on account of long-established by-laws and rules of our institution we have not been able to work out a plan that permits our accepting patients to be attended by physicians who have not the approval of the local medical society.

"We appreciate very much your interest in our institution in connection with this matter, and it is our hope that the Medical Society and the officers of the Group Health Association may soon find a solution to their differences, as we understand they are still working toward that end.

"Very truly yours,
"S. H. Rogers
President, Board of Directors
Eastern Dispensary and Casualty Hospital"

By Mr. Lewin:

Q.—That letter refers to some explanation which Mr. Rogers gave you and Mr. Loomis. Was that at the conversation which you testified you had with Mr. Rogers some time in June of 1938? *A.*—It was.

Q.—Will you state to the jury what the conversation was at that meeting, what you said and what was said by these people representing the hospital? *A.*—In substance, it was this. We again offered our plea for admission of the members of our staff to Casualty Hospital, and Mr. Rogers led the conversation for the other group, and he said that it had been a tenet of their by-laws for some fifty years that no admission to the courtesy staff of that hospital could be made unless the applicant were a member of the District Medical Society; and he offered that as the one and only stumbling block in the way of admission of any of our staff members to that hospital. I offered at that meeting to enter into a contract with that hospital to take over one of its bays—

Q.—What is that? *A.*—Sick bays—they call them bays or wings of the hospital—which I understood contained approximately 40 beds; that we would rent these beds under contract, provided the hospital would admit our physicians to treat patients who might occupy those beds. But again he offered the objection that the by-laws of the hospital would prevent such action. Finally, addressing Dr. Rogers Young, I think his name is, who I understood was the man in charge of the surgical staff of that hospital, or its medical staff, I said to him, "Doctor, when are you hospital people going to stand up on your hind feet and assert your rights in this question?" His reply was that he did not know. After a little more discussion about the subject in general the meeting ended.

Q.—Was the defendant J. Rogers Young present during the entire interview? *A.*—My recollection is he was there during the entire interview.

CROSS EXAMINATION

By Mr. Leahy:

Q.—When you opened up the conversation you were then advised that for a period of approximately fifty years the rules and regulations of the hospital were such that they could not admit doctors to the staff who were not approved by the local medical soceity? *A.*—No; he didn't say that.

Q.—What did he say? *A.*—Mr. Rogers said that it had been a part of their by-laws for upwards of 50 years that admission to the courtesy staff of their hospital was confined to members of the District Medical Society.

Q.—What you wanted them to do was to change those by-laws to admit your doctors; is that right? *A.*—I wanted them to do anything they thought best to do.

Q.—To do that you knew they would have to change the by-laws which had been in effect fifty years? *A.*—Perhaps.

Q.—You knew that, didn't you? *A.*—No; I didn't know that at all. I had nothing to do with what they should do. All I was interested in was in getting our staff in there. How they did it I wasn't concerned with.

Q.—But you knew they could not get in there unless they changed the by-laws which had been in force for fifty years? *A.*—Yes; from the statement of Dr. Rogers.

Q.—Notwithstanding that, you still persisted, did you, to get this letter of June 11— *A.*—I wouldn't say I persisted; no.

Q.—You went to Mrs. Meyer, did you not, and asked her to write? *A.*—I first asked her to call a meeting. Mrs. Meyer said she didn't have time to call a meeting, but would be glad to write a letter.

. . . . . .

Q.—You told him you would fill up one of the sick bays? *A.*—I did not.

Q.—You told him you would hire one of the sick bays? *A.*—I told him I would offer to.

Q.—You mean, you would, don't you? *A.*—Yes, if he would.

Q.—That is, G. H. A. would rent one of the sick bays in Casualty Hospital? *A.*—Yes.

Q.—In connection with that do you recall that Mr. Rogers said anything about the fact that Casualty Hospital was incorporated to take care of the poor? *A.*—No. I recall no such statement as that. He may have made it, but I don't recall it.

Q.—See if I can refresh your recollection. Do you recall whether Mr. Rogers said to you that Casualty Hospital was incorporated to take care of the poor and the indigent, and you replied, "We are not interested in that"? *A.*—No; I don't recall any such thing.

Q.—Would you say it was not said? *A.*—I will say that I don't think I said it.

Q.—Was there anything said that Casualty Hospital was approaching its 50th anniversary of existence? *A.*—I don't recall that. The only reference to 50 years was Mr. Rogers' statement about the by-laws.

Q.—Did you then tell Dr. Rogers that if he would let you take this bay of forty beds you would get Mr. Acton, the publicity agent for G. H. A., to push Casualty and give them great publicity on their fiftieth anniversary? *A.*—Never made any such statement.

Q.—Nothing like that in substance? *A.*—Nothing like that, approaching it, near it, or anything around that.

Q.—Did Mr. Loomis make any such statement? *A.*—I don't know.

Q.—You were there, weren't you? *A.*—I was there, but I don't recall his making any such statement.

Q.—Would you say he did not make such a statement? *A.*—I will hazard a guess that he didn't make it.

Q.—So your answer as to this conversation is that nothing was said about the incorporation of Casualty Hospital to the end that it was to take care of the sick and the indigent, in which you were not interested? *A.*—Nothing that I recall at all about that.

Q.—And that nothing was said about booming Casualty if they would let G. H. A. patients take over that bay? *A.*—No. We had no interest in booming Casualty or anything else.

Q.—Did you have a publicity agent? *A.*—No, sir; I did not.

Q.—Who was Mr. Acton? *A.*—Howard Acton; chairman or director of public relations for the Federal Home Loan Board.

Q.—Did he have anything to do with establishing G. H. A.? *A.*—I don't think he did anything toward it.

Q.—Did he carry on publicity for G. H. A. in the papers? *A.*—I don't know how much of it—

Mr. Lewin:—Objection.

THE COURT:—Sustained.

By Mr. Leahy:

Q.—When was it you talked to Mr. Aspinwall? *A.*—I think it was in August 1938.

Q.—You recall a letter in January having been received from Garfield? *A.*—I recall a letter having been addressed to Dr. Selders in January.

Q.—You know that Garfield Hospital told you then, do you not, that until the question of the legality of Group Health Association was determined, they could not admit Dr. Selders on the staff? *A.*—They didn't tell me anything.

Q.—You saw that in a letter, did you not? *A.*—They told Dr. Selders that.

Q.—I am talking about you, now, as Group Health Association. *A.*—Fine!

Q.—This letter which was received by Dr. Selders was turned over to your files, was it not? *A.*—Yes.

Q.—And you saw the letter in your files? *A.*—Yes.

Mr. Lewin:—That has already been testified to.

By Mr. Leahy:

Q.—So you knew in January, did you not, that Garfield Hospital had taken the position that it could not admit Dr. Selders to staff privileges in Garfield until the legality of G. H. A. was determined? *A.*—I knew that was the statement of the Superintendent, but I didn't know that that was the policy of Garfield Hospital.

Q.—You do know that that was the policy as stated to you by the Superintendent, through Dr. Selders? *A.*—No. I know it was the expression of the Superintendent; that is all.

Q.—You did not think he was speaking for the hospital? *A.*—I didn't think anything; I didn't know.

Q.—Did you deny in any way at all to him that that was the policy of Garfield? *A.*—No.

Q.—It was not discussed in the conversation? *A.*—It was not.

Q.—And he, as a member of the Board, did not bring up to you the fact that the hospital had discussed this matter in the previous January and determined that they could not admit such doctors until the question of legality had been determined? *A.*—No legality was ever mentioned at all. I said on the stand this morning that the only reference to that question was the statement that I knew that Dr. Selders had been denied privileges in January.

Q.—But the reason for that denial was not discussed? *A.*—It was not.

Q.—At that very time, along in January, you had made application to Garfield, had you not, for the admission of Dr. Selders? *A.*—I am not sure that I made it to Garfield. I don't think so, because he was already in Garfield at that time when I became president.

Q.—You became president and took over your duties on January 18, did you not? *A.*—That is correct.

Q.—And within ten days you got this letter from Garfield? *A.*—About that: it was January 25.

Q.—Did you then make an application to Garfield for privileges? *A.*—I think, perhaps, on February 2nd, but not in January.

Q.—You know you did, don't you? *A.*—Well, if I did I know I did.

Q.—Have you any doubt about it? *A.*—I just don't know I did—because you offered that as a statement. If I did I know I did.

Q.—Did you not testify on Monday that on February 2nd you made another appeal to all the hospitals in Washington? *A.*—Oh, yes; sure.

Q.—Then you did go to Garfield with this appeal? *A.*—Yes.

Q.—Why did you say "If I did I did," then? *A.*—Because I am not going to have you put words into my mouth.

Q.—I am not doing that. I am asking you to answer a question which is directly put to you. Now listen, please— *A.*—If you will let me do that, we will get alone fine.

Mr. Lewin:—I object to all this bullyragging by counsel. Show him the letter.

Mr. Leahy:—You have got it. Give me the February 2 letter to Garfield.

Mr. Lewin:—You are showing off here at a great rate.

Mr. Leahy:—If you Honor please, I am trying to do the best I can.

Mr. Lewin:—You are trying to bullyrag this perfectly honest witness about a letter, and you have the letter in your hand.

THE COURT:—Mr. Leahy, if you have got the letter now, let us go on.

By Mr. Leahy:

Q.—You did write to Garfield on February 2nd? *A.*—Yes.

Q.—And you knew when you wrote on February 2nd that on the 28th day of January you had signed a petition for a declaratory judgment in this court? *A.*—I signed such a petition; I don't know what date it was.

Q.—I am going to show you the petition and ask you if your signature appears where I am indicating. *A.*—That is my signature.

Q.—And in that respect you were represented, were you not, by Horace Russell, Mr. Keeley, Mr. Long and Mr. Newton? *A.*—That is correct.

Q.—All counsel for the Home Owners' Loan Board? *A.*—All employees of the Home Owners' Loan Corporation.

Q.—And you swore to it, did you not, on January 27? *A.*—That is correct.

Q.—Your signature appears there, does it not? A.—It does.

Q.—And you had sworn to this petition in this court—you can read over those pages to refresh your recollection if you wish. *A.*—I wouldn't understand them, but I will take your word that they are there.

Q.—You have no difficulty in understanding what you swore to, have you?

THE COURT:—Put your next question, Mr. Leahy.

Q.—Did you swear on the 27th of January that on or about Jan. 15, 1938—

Mr. Lewin:—I object to that as immaterial.

Mr. Leahy:—This is on the cross of what he said on direct.

Mr. Lewin:—He didn't say anything about this suit on direct.

Mr. Leahy:—Oh, yes he did.

Mr. Kelleher:—Another objection, your Honor, he is trying to read to this witness these conclusions of law from this suit for declaratory judgment.

THE COURT:—I would like to hear the question. I cannot rule on it until I do.

By Mr. Leahy:

Q.—Did you swear on January 27 that on or about Jan. 15, 1938 notice was given by the defendant, David A. Pine, Acting United States District Attorney for the District of Columbia, to the plaintiff, that, unless operations were immediately suspended and the affairs of the plaintiff were wound up, a bill for injunction or legal proceedings looking to the involuntary dissolution of the plaintiff corporation would be brought against the plaintiff on the ground that it, said plaintiff, is illegally engaged in the practice of medicine, as the same is defined by the Healing Arts Practice Act in the District of Columbia, and is illegally engaged in the insurance business within the meaning of Title V, Chapter 7, Section 179 of the Code of Laws of the District of Columbia?

Mr. Lewin:—We object to that as immaterial. It is outside the scope of the direct examination.

Mr. Leahy:—He went into it on direct examination.

Mr. Kelleher:—What difference does this make?

THE COURT:—I am ready to rule.

Mr. Leahy:—May I approach the bench?

THE COURT:—Yes.

(Counsel for both sides approached the bench.)

. . . . . .

By Mr. Leahy:

Q.—I show you Government's Exhibit 433 and ask you if that is an answer to your letter of February 2, Government Exhibit 432? *A.*—I would say it was.

Q.—Now he says there if you want to drop into the office and discuss the matter, he would be glad to talk to you. Did you do it? *A.*—Yes, we dropped in his office.

Q.—Then you did see him before this conversation? *A.*—No. I only saw him once. Whenever that conversation took place, that was the time.

Q.—You had only the one conversation? *A.*—Yes.

Q.—Now I ask you to look again at Government's Exhibit 432 and tell me whether you discussed the legality of G. H. A. *A.*—I still say we did not.

Q.—Isn't Government Exhibit 432 the very thing you wanted to talk about? *A.*—It may have been the thing we wanted to talk about, but it isn't the thing we talked about. You asked me what we talked about. Now, that isn't what we talked about.

Q.—All right. On Feb. 2, 1938, you wrote to Mr. Aspinwall that you felt there may have arisen some misunderstanding concerning the legality of our operation and in order that the question may be discussed and a clear understanding had by both parties, it is respectfully requested that the representatives of Group Health Association, Inc., be accorded the privilege of appearing before your Board of Trustees for the purpose of discussing the situation with them. *A.*—That's fine. I wrote that letter.

Q.—All right. Now on February 3 you received back a letter from Mr. Aspinwall saying "I would be glad to discuss the matter. I should be glad to talk to you." *A.*—Yes, we did.

Q.—Now, you went there to discuss what you said in your second paragraph of your letter of February 2nd? *A.*—No, we did not discuss that.

Q.—Just a moment. On February 2 that is the thing you wanted to discuss, isn't it? *A.*—That is one of the things we wanted to discuss.

Q.—Is there anything else you stated in your letter of February 2nd you wanted to discuss? *A.*—I—

Q.—Was there anything other than the legality of G. H. A.? *A.*—Not in the letter.

Q.—Now, when you did get in this discussion, the only thing you didn't discuss was the thing you wanted to discuss in your letter of February 2nd? *A.*—No, we didn't necessarily want to discuss it at all. We didn't think it was a pertinent question. If Mr. Aspinwall wanted to discuss it, fine, and good, we were ready to discuss it.

Q.—But you didn't bring on the discussion at all? *A.*—We did not.

Q.—You knew at that time, did you not, that the suit which you swore to and which you just identified your signature on, had been filed in this Court, about three or four days before? *A.*—I knew that such a paper had been filed.

Q.—And that was the question you wanted to raise in your suit, was the legality— *A.*—No, I am not a lawyer, Mr. Leahy. I don't know anything about legal matters at all.

Q.—You don't mean to tell the jury that you didn't know what was involved in that suit? *A.*—That isn't what your question was and that isn't what my answer was.

Q.—Will you now say that the suit— *A.*—I have already admitted I knew that.

Q.—And you filed the suit four days before you wrote the letter of February 2? *A.*—Yes, and had no question of the suit in my mind when I wrote the letter; none whatever.

Q.—In your letter of February 2 in the second paragraph you had no reference— *A.*—No reference or question in my mind or anything else of that suit, and I want to make that as clear and emphatic as I possibly can; and if you want it repeated, I will be glad to repeat it.

THE COURT:—Mr. Witness.

The Witness:—Yes.

THE COURT:—Please contain yourself.

Mr. Kelleher:—Your Honor, I do think his attitude is understandable.

THE COURT:—I am speaking to the witness now, not counsel.

Mr. Kelleher:—I want to make a representation to the Court.

THE COURT:—I want to say to the witness and I want to say to counsel too, I don't want this to get into a personal wrangle between counsel and the witness. I am simply wanting both sides to maintain the cross-examination on a plane that is proper.

Mr. Kelleher:—I think, your Honor, it is fair to the Government to say this witness' attitude is very understandable.

THE COURT:—I think his answers should apply to those letters.

By Mr. Leahy:

Q.—Now, let us get to the Episcopal Hospital. You wrote a letter on February 2nd to them also, didn't you? *A.*—That is correct.

Q.—Did you ask privileges for all your doctors in Episcopal? *A.*—No, sir.

Q.—For whom did you ask privileges? *A.*—Dr. Dabney.

Q.—Wasn't Dr. Dabney on the staff? *A.*—Dr. Dabney was on the staff, as I understand it.

Q.—Just what were you asking for at Episcopal? *A.*—Because Dabney couldn't take our patients in as a member of our Association; as I said the other day, he took them in through the back door.

Q.—Did he take patients to Episcopal Hospital? *A.*—He did.

Q.—How many patients did he take in? *A.*—Approximately 50 at that time.

Q.—Did he pay for them? *A.*—Yes, sir. They paid approximately $14 for each patient.

Q.—Did the Episcopal refuse to take your checks? *A.*—No, sir.

Q.—So that Dr. Dabney took 50 patients of G. H. A. into the Episcopal Hospital for which G. H. A. paid by its checks? *A.*—That is correct.

Q.—Right? *A.*—Right.

Q.—Was Dr. Dabney ever removed from the staff of Episcopal? *A.*—Not that I ever heard of.

Q.—You know that Dr. Dabney had been on the staff of Episcopal Hospital for a good many years? *A.*—He told me he had been.

Q.—And you know he remained there notwithstanding he was connected with G. H. A.? *A.*—Well, do you want me to tell you what he told me?

Q.—I asked whether you knew he remained on the staff. Yes or no. *A.*—Yes, he remained on the staff.

Q.—Now, are you sure that there was any problem at all about Dr. Dabney getting patients of G. H. A. in the hospital? *A.*—Well, that resolves itself around what he told me, Mr. Leahy, which has a very direct connection with the question if you would like me to say it.

Q.—I will let you say it and we will be glad to get it. *A.*—Dr. Dabney told me they dared not touch him in Episcopal, that they had to let him bring patients in there, even by the back door.

Q.—Is that what Dr. Dabney said? *A.*—Yes, sir.

Q.—Then you did yet your G. H. A. patients in there? *A.*—We did under this surreptitious arrangement.

Q.—What was the surreptitious arrangement? *A.*—That he wasn't admitted there as a surgeon or physician recognized by the hospital as being on our staff. He was there as a private physician, and he brought our members in there as his private patients. Now that—

Q.—Have you ever—have you finished? *A.*—I just wanted to say one more thing. We wanted him recognized as a member of our staff. We didn't like this business of him having to take patients in there quietly, any more than he did.

Q.—Did you ever talk with anybody of the Episcopal Hospital about this? *A.*—I never saw or spoke to a single one of them.

Q.—What information you got you got from Dr. Dabney? *A.*—I got right from Dr. Dabney.

Q.—Did you, as President of the Corporation, have any difficulty in having G. H. A. cases treated there? *A.*—We never had a bit of difficulty that I ever heard of.

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Q.—In other words, any G. H. A. patient who was under Dr. Dabney's care while Dr. Dabney was with you, was treated at the Episcopal Hospital without any difficulty? *A.*—Yes, sir.

Q.—Now, at Columbia you had a series of letters, I think, which you wrote, beginning again on February 2. Is that right? *A.*—February 2. That's right.

Q.—Now did you ask for privileges for all your members at Columbia? Yes or no. *A.*—The letter speaks for itself, Mr. Leahy. I don't recall just exactly the wording of the letter, but I think it asks for privileges for all the members. It may not have.

Q.—So then was that the same letter which you sent to all the hospitals? *A.*—It was an identical letter, yes.

Q.—Were they carbons or identicals? *A.*—They were originals in each case.

Q.—But typed the same. Is that it? *A.*—Typed the same.

Q.—Did you ever discuss the matter at all with anybody at Columbia? *A.*—No, sir. I had no connection whatever, or discussion, with anybody at Columbia Hospital.

Q.—Did you conduct correspondence with Columbia as President of the Group Health? *A.*—I think I had two or three letters in response to mine of February 2 and perhaps the one of July 28th.

Q.—The one whom you wished to have on the staff at Columbia was Dr. Selders, wasn't it? *A.*—Not necessarily Dr. Selders. At that time we had no obstetrician on the staff. Dr. Selders felt himself qualified to administer or treat a limited degree of obstetrics.

Q.—Now did he get the privilege at Columbia? *A.*—I don't think he ever did.

Q.—Are you sure about that? *A.*—No, sir. I am just telling you my recollection.

Q.—Did you state on Monday that he never got any privilege in Columbia? *A.*—Did I what?

Q.—Did you state on Monday that Dr. Selders was not permitted to go to Columbia? *A.*—I perhaps did.

Q.—Why did you make that statement? *A.*—Well, that was my recollection.

Q.—On what was your recollection based on Monday? *A.*—On my memory.

Q.—Has your memory changed now, since Monday? *A.*—No, sir.

Q.—Will you tell the jury whether he did or did not get the privilege? *A.*—My answer is exactly the same as it was on Monday.

Q.—What is that? *A.*—That I don't recall whether he ever treated anyone there or not, but I do know that he wanted to get this limited obstetrical arrangement, as he described it.

Q.—See if I can refresh your recollection, Mr. Kirkpatrick. At the time you were writing these letters to the hospitals, and more particularly this one to Columbia, didn't you know that Dr. Selders was asking for the widest privileges for a surgeon to ask? *A.*—Mr. Leahy—

Q.—Yes or no. *A.*—No, I don't know anything about that, what he was asking for.

THE COURT:—Don't extend your answers where it is not necessary. Where you can answer yes or no, please do so, and then you may explain if necessary.

By Mr. Leahy:

Q.—Now you state in this letter of February 2 that you had before you the letter of Dec. 15, 1937, addressed to Mr. William F. Penniman. *A.*—Yes.

Q.—Penniman was your predecessor in office, wasn't he? *A.*—Yes.

Q.—And you had been looking over the file, hadn't you, to see what Mr. Penniman had done with relation to Dr. Selders? *A.*—I may have looked over that file. I don't know whether I looked over the file or not. I had it in my files, but I don't know whether I looked at it.

Q.—You said "I have before me your letter of December 15th addressed to Penniman." *A.*—That is true. It may have been in my file.

Q.—You had it before you when you were dictating this. *A.*—Not necessarily.

Q.—At least you had it in your mind, didn't you? *A.*—I wouldn't say I had it in my mind.

Q.—Where did you have it? *A.*—I knew that Fred Penniman had written such a letter before I came into office.

Q.—Now then in your letter—that is referring to Ashburn—you say in this letter of yours of February 2 that the Medical Board would meet on December 23 to make a recommendation with respect to the application of Dr. Raymond B. Selders for privileges of the Courtesy Staff of your hospital. *A.*—That's right.

Q.—Now you didn't inquire about any other doctor, did you? *A.*—No, sir.

Q.—So far as you knew when you wrote that letter there was no other doctor connected with Group Health who had made any application to Columbia Hospital? *A.*—Yes, sir.

Q.—Haven't you any recollection of the privileges for which Dr. Selders made application? *A.*—No, sir. I had nothing to do with it.

Q.—Didn't you look in the files in order to write this letter of February 2 for the type of privileges which Dr. Selders sought? *A.*—I didn't say I did—

Mr. Kelleher:—Objected to as immaterial.

By Mr. Leahy:

Q.—I asked you if you didn't know when you wrote that letter of February 2 that Dr. Raymond B. Selders had made application for the widest surgical privileges on that staff of Columbia Hospital for which a surgeon could apply?

Mr. Kelleher:—I object.

THE COURT:—He has answered it once.

By Mr. Leahy:

Q.—Well, what did you think Dr. Selders had applied for? *A.*—I didn't think. All I wanted of him was to be admitted to the hospital, for whatever thing he thought he could do. I had nothing to say with what he thought he could practice there. That is his business. I am a layman.

Q.—Well, why didn't you let Dr. Selders make the application? *A.*—Because it was necessary for everybody to help. We just regret we didn't have a hundred people trying to get them in there.

. . . . . .

Q.—Now, in that letter on February 5 you learned, didn't you, they had failed to act on Dr. Selders' application for courtesy privileges, that is, the Medical Board, and consequently the Medical Board had made no recommendation in the matter to the Board of Trustees, Directors. *A.*—That is correct.

Q.—And Dr. Selders' status with relation to this hospital remains unchanged? *A.*—Yes.

. . . . . .

By Mr. Leahy:

Q.—Mr. Kirkpatrick, you have been over the testimony you were going to give today, haven't you, before you took the stand? *A.*—Yes.

Q.—And you came down here and refreshed your recollection by going through the files of Group Health? *A.*—I didn't go through any files of Group Health.

Q.—Didn't you have letters presented to you so your memory might be refreshed? *A.*—Oh, yes. I did that. I thought you meant me going through the files.

Mr. Kelleher:—Is it pertinent to this case to have this witness testify now orally whether he wrote letters that he had testified already he wrote? Is there any point in it?

THE COURT:—The only matter, he says he didn't write any letters, has no recollection of it.

Mr. Kelleher:—Is that important to the case?

THE COURT:—It is only important in this way, this man on cross-examination may have his credibility tested, which of course involves his statements, recollection, and that sort of thing.

Mr. Kelleher:—I suggest it has no bearing upon this witness' credibility to ask him about a series of correspondence without showing him the correspondence.

THE COURT:—He is asking him the fact as to whether he had written any other letters. Proceed.

By Mr. Leahy:

Q.—You have no recollection of it now? *A.*—No, I haven't, Mr. Leahy.

Mr. Leahy:—Are there other letters there?

Mr. Lewin:—There are other letters here.

Mr. Kelleher:—You expect the witness to remember that and you can't even find them.

Mr. Leahy:—I didn't expect the witness to remember them.

By Mr. Leahy:

Q.—I will ask you if you remember the letter of March 3, 1938, in which Columbia Hospital advised Group Health that Dr. Selders had been given the privileges which you say he wanted to obtain? *A.*—No, I don't remember that letter.

Q.—You don't remember that letter? *A.*—Who was that letter addressed to?

Q.—Was it addressed to the Group Health or Dr. Selders? *A.*—I am asking the question. I don't recall the letter.

Q.—Don't you know as a fact that Dr. Selders had privileges in Columbia Hospital as a representative of G. H. A. and as

one of your staff members from March 1938 for obstetrical work? *A.*—Yes, he may have had such a status there, yes. I don't deny that he did. But you are asking me for a recollection.

Q.—I am asking you as the President of your Association and who, you have just said, was so interested in getting these things that you wished you had a hundred people. *A.*—Yes. I do.

Q.—Wasn't that interest sufficient for your recollection to reach the end, that Dr. Selders was given those privileges? *A.*—Yes, it would be, but perhaps not sufficient to refresh my recollection at this time.

Mr. Kelleher:—I want to ask counsel now whether he had any basis for that question about the March 3 letter. Is there such a letter?

Mr. Leahy:—Yes, sir. You should have found it, going through the files, too.

Mr. Kelleher:—Can you show it to me now?

Mr. Leahy:—No.

Mr. Kelleher:—There is no such letter, to our knowledge.

Mr. Leahy:—That may be true. Go through, you will find a lot of letters we cannot find.

By Mr. Leahy:

Q.—Did you know about the action of the Board of Columbia Hospital that Dr. Selders had been admitted? *A.*—No, I was never so notified.

Q.—Did you know that Dr. Selders wasn't found qualified for major surgery for which he asked? *A.*—No.

Q.—You don't seem to know anything about Dr. Selders and Columbia after the letter of February 5, do you ? *A.*—I wouldn't say that, Mr. Leahy, no.

Q.—Now, let us go to Garfield. You knew, did you, that Mr. Penniman had written to Garfield Hospital requesting that Dr. Selders be admitted on the staff of Garfield? *A.*—Oh, yes.

Q.—And you knew that he had been granted temporary privileges, didn't you? *A.*—I did.

Q.—And then you knew on about the 25th or 28th of January 1938, that the temporary privileges had been withdrawn? *A.*—Yes.

Q.—And would you say the ground for withdrawal was—

Mr. Lewin:—We object to it. We have been all over this on both direct and cross.

The Court:—I don't remember it.

Mr. Lewin:—On Garfield? This witness has testified to it fully on both direct and cross.

The Court:—I don't know what he is leading up to, Mr. Lewin.

By Mr. Leahy:

. . . . . .

Q.—Now did you know or do you know whether or not an application was made for any of the members of your staff at Garfield Hospital? *A.*—Yes. I think Dr. Halstead made an application as early as August.

Q.—August of what year? *A.*—1938.

Q.—Did they make an application at Garfield before August 1938? *A.*—My recollection is that Dr. Selders was the only one that made such an application.

Q.—Do you know whether there were any of the members of your staff who had courtesy privileges at Garfield Hospital besides Dr. Selders on temporary? *A.*—Perhaps Dr. Cahoon, either in the very early part of 1939, or the last of 1938.

Q.—You mean the early part of 1937? *A.*—No, I mean 1939.

Mr. Kelleher:—I object to that, and move that be stricken. It is outside the scope of the indictment.

The Court:—Yes. Confine yourself to that.

By Mr. Leahy:

Q.—Do you know whether two of the members of your staff had courtesy privileges at Garfield Hospital in '37 and '38? *A.*—Oh, you mean Dr. Scandiffio and Dr. Lee?

Q.—Yes. *A.*—Oh. I knew that, yes.

Q.—Why didn't you tell us that when I asked? *A.*—Mr. Leahy, I am doing the best to recall these things. Now if I slip in recalling them, I am not to be condemned for that, I don't think.

Q.—Why didn't you mention Cahoon in 1939? *A.*—I understood Cahoon made application to Garfield Hospital late in 1938, and that is the period I am talking about.

Q.—Now I am talking about the period of '37 and '38. *A.*—Fine.

Q.—Dr. Lee and Dr. Scandiffio were on the staff of Garfield? *A.*—Before we opened our doors, or afterwards?

Q.—Well, first, when were they on the staff? *A.*—I don't know when. I just know they said they had been on that staff.

Q.—Do you know whether they were on the staff? *A.*—Of my knowledge, no.

Q.—You don't know that? *A.*—Only what they told me.

Q.—Were there two other applications to Garfield Hospital besides Scandiffio and Lee which were acted favorably upon after you opened up your clinic? *A.*—Some year or so later.

Q.—Well, earlier than a year or so later. *A.*—No, I never heard of any other than Selders.

Q.—How frequently were you at the office? *A.*—What is that?

Q.—How frequently were you at the office of G. H. A.? *A.*—I guess I was there about once a week on the average, or perhaps sometimes every few days.

Q.—Who handled the correspondence for G. H. A.? *A.*—Well, now, that is a big question. What correspondence are you speaking of?

Q.—Well, did you handle the official correspondence for G. H. A.? *A.*—I handled some of it.

Q.—Who handled the rest of it? *A.*—Our Administrator.

Q.—Who was he? *A.*—Mr. Perry Taylor. And the Medical Director.

Q.—When did Perry Taylor come in office? *A.*—Perry Taylor came in office July 1938.

Q.—Who handled it from January 1938, when you took office, down to July? *A.*—We had no Administrator.

Q.—I know that, but who handled the correspondence? *A.*—I handled some of it. Mr. Barry, who was then treasurer, handled some of it. Dr. Brown, who was then Medical Director, handled some of it.

Q.—Who handled the correspondence with reference to applications for courtesy privileges at hospitals? *A.*—I handled them and Mr. Penniman handled them and the doctors handled them.

Q.—Did Dr. Brown handle any correspondence with reference to applications for courtesy privileges? *A.*—I don't know whether he did or not. I question whether he did, but he may have.

Q.—Isn't it a fact that the correspondence went through your office? *A.*—I wouldn't say all of it did.

Q.—The correspondence with reference to applications for staff privileges?

Mr. Lewin:—Objected to as immaterial. What possible difference could it make whether the correspondence went through his office or not?

Mr. Leahy:—I was just trying to search his recollection.

Mr. Lewin:—Recollection about what?

By Mr. Leahy:

Q.—Well, then, you didn't wish to leave with the jury on Monday last the impression that none of the doctors of your staff had courtesy privileges at Garfield during this period, did you? *A.*—Yes. I think that is a fair impression to leave with this jury. I don't see anything in the picture that would lead otherwise.

Q.—Well, you don't know much as to whether there were two or four members of your staff? *A.*—I think I have a pretty good knowledge of the general picture, Mr. Leahy. If you are going to get down into details I may be a little hazy on details.

Q.—All right. Answer the simple question. *A.*—Yes.

Q.—In 1937 and 1938 how many members of your staff had courtesy privileges at Garfield? *A.*—From my conversation with them I should say that Dr. Scandiffio and Dr. Lee had courtesy privileges in 1937, but from my conversation also with them I should say that they didn't have them in 1938.

. . . . . .

Q.—Now, you again filed a letter with Sibley dated February 2, didn't you, 1938? *A.*—Well, if that letter is here, I certainly wrote it.

Q.—Do you recall getting any reply from Sibley Hospital with respect to that matter? *A.*—I don't recall getting any reply with respect to that matter. I do with respect to another matter.

Q.—Do you recall receiving word from Sibley Hospital that they had investigated the vouchers of Dr. Selders and had gotten no reply on them and therefore that they could not give Dr. Selders courtesy privileges because he hadn't shown himself qualified? *A.*—I remember seeing some correspondence that all of Dr. Selder's references hadn't been heard from.

Q.—You identified those on Monday, didn't you (indicating)? *A.*—Yes.

Q.—Did you ever investigate any of those vouchers yourself as President of G. H. A.? *A.*—No, sir. I had nothing to do with them.

Q.—When did you first meet Dr. Selders? *A.*—In June of 1937.

Q.—He had just graduated from his intern residency at Worcester Hospital, hadn't he? *A.*—I don't know.

Q.—Well, you were on the Board, weren't you, which ratified his selection? Weren't you on the Board of Directors or the Trustees of G. H. A. which hired Dr. Selders? *A.*—Yes, sir.

Q.—Well, now, do you mean to say that you don't know that Dr. Selders had just come from Worcester Hospital? *A.*—No, I don't say I don't know. I say I don't recall now. He may have graduated a week before or ten years before.

Q.—But you don't know that now? *A.*—No.

Q.—He was your only surgeon? *A.*—Yes.

Q.—You were hiring the only surgeon then for five thousand or six thousand people, weren't you? *A.*—Yes.

Q.—And you don't know now what his qualifications were? *A.*—No, I don't. And I have no apology in that respect.

Q.—Now I ask you whether you wrote to Sibley on February 2 (indicating)? *A.*—That is a copy of my letter to Sibley.

Q.—Just like you wrote the other hospitals? *A.*—Yes, sir. If not identical.

Q.—Do you recall when it was that you received Sibley Hospital's reply that it had tried to find out the qualifications of Dr. Selders but it couldn't? *A.*—I don't think I received that reply. I think it came to Dr. Selders.

Q.—Well, did you see it? *A.*—Yes. You asked me if I received the reply.

Q.—It went into the clinic's file, didn't it? *A.*—Yes.

Q.—Then you know what I am talking about? *A.*—Yes. You asked me if I received a reply and my answer was no.

Q.—Let us see how good your recollection is. It came to you personally, didn't it? Take a look at the letter. (Indicating.) *A.*—Yes, sir. That came to me personally.

Q.—Wrong again? *A.*—Perhaps I may be wrong many times.

Mr. Kelleher:—What does it prove? There is no issue of credibility involved in regard to this witness.

THE COURT:—There is a question of credibility that arises with every witness.

Mr. Kelleher:—With regard to these letters.

THE COURT:—A general question of credibility. This witness has testified to many things. He was on the stand here a whole day.

Mr. Kelleher:—All right. Has it any bearing on his credibility that he forgets whether the letter came to him or Dr. Selders?

THE COURT:—Whether he forgets or not is not for me to say. That is a question of fact for the jury. I don't pass on the credibility.

Mr. Kelleher:—There must be some limit.

THE COURT:—Some fair limitation. I will exercise that fair limitation myself.

By Mr. Leahy:

Q.—Now what steps did you take afterwards on that letter from Sibley Hospital to you to supply Sibley Hospital with the information they were asking for? *A.*—I didn't take any steps except to ask Dr. Selders if he had gotten in touch with his references to see if they could make reply to whatever letters were necessary. I remember asking him to do that, on the telephone.

Q.—Is that all you did as President of the Association? *A.*—Yes, sir.

Mr. Lewin:—May I see the letter you show the witness, please?

Mr. Leahy:—Surely.

By Mr. Leahy:

Q.—Do you know now whether Dr. Selders ever supplied that information, Mr. Kirkpatrick? *A.*—I remember seeing a letter here acknowledging the receipt of three or four—out of four, I understand.

By Mr. Lewin:

Q.—Isn't that in this very letter (indicating)? *A.*—Yes, sir. He says he received three of them, in that letter. That is the letter I referred to.

By Mr. Leahy:

Q.—Now on the 24th of February did you see a letter which was addressed to Dr. Raymond Selders over Dr. Taylor's signature? *A.*—Yes. Dr. Selders turned that over to my file.

Q.—On February 24 Dr. Taylor advised Dr. Selders that he regretted to inform him that the Committee "did not reverse the action and your request has been refused." Is that right? *A.*—That's right.

Q.—Now with reference to Sibley, can you tell us what character of privileges you asked for Dr. Selders? *A.*—I didn't ask for any privileges.

Q.—Well, what were you asking for? *A.*—Admission to the Courtesy Staff.

Q.—To do what? *A.*—To do anything that he or they agreed he could do. We didn't undertake to say what these doctors should practice. It is up to them to arrive at that conclusion.

Q.—Have you ever had any experience at all before you became President of Group Health Association in any medical—*A.*—No.

Mr. Kelleher:—Wait a minute. Don't answer so quickly. I object to that. It has no bearing whatever.

THE COURT:—Objection sustained.

By Mr. Leahy:

Q.—Well, did you think when you wrote the application, Mr. Kirkpatrick, that Dr. Selders would be permitted to do everything in the hospital?

Mr. Kelleher:—Don't answer so quickly. I object to that as incompetent, irrelevant and immaterial.

Mr. Lewin:—And as already answered.

THE COURT:—Objection sustained.

Mr. Leahy:—The only point is, if your Honor please—

Mr. Lewin:—Well, Mr.—

Mr. Leahy:—Won't you please let me address myself to the Court, Mr. Lewin?

Mr. Lewin:—Yes. I am sorry.

Mr. Leahy:—The point I wish to bring out is I want to clear up, if I can, the question surrounding the application of Dr. Selders in these various hospitals. I am trying to find out just what character or type of courtesy privileges he was seeking. That is all I am asking.

THE COURT:—That is shown by the applications.

Mr. Leahy:—We haven't any applications in evidence.

THE COURT:—I may be mistaken, but I think that in every instance where the application is made by Mr. Kirkpatrick he was supported by a formal application of Dr. Selders.

Mr. Leahy:—No, your Honor, he wasn't.

Mr. Kelleher:—That was Penniman's applications, but Penniman's applications were excluded upon motion by counsel for defense. If he wants to offer them, he can.

Mr. Richardson:—There were no applications excluded.

THE COURT:—I think I understand the situation. Mr. Penniman said he made a general application for admission to the Courtesy Staff. He didn't deal with the details of it as far as the man's qualifications. I think that is as far as you can go.

Mr. Leahy:—Yes, your Honor.

FEBRUARY 28—AFTERNOON

TESTIMONY OF WILLIAM C. KIRKPATRICK
(RESUMED)

By Mr. Leahy:

Q.—Mr. Kirkpatrick, did you personally ever go to Providence Hospital? *A.*—No, sir, I never was in that hospital in my life.

Q.—Did you ever meet Sister Ross personally? *A.*—Never.

Q.—Did you ever meet Sister Rodriquez at Georgetown? *A.*—No, sir.

Q.—Did you go to Georgetown personally? *A.*—Never.

Q.—Do you recall whether or not you received any correspondence from either or both of these hospitals? *A.*—It seems to me that I received correspondence from both.

Q.—Was it with reference to Dr. Selders' application at Georgetown and Providence? *A.*—I think so.

Q.—Was it to the effect, in substance, that Dr. Selders' application in either or both of these hospitals had been disapproved? *A.*—My recollection is that they had either been disapproved or no decision made.

Q.—Did you ever follow that correspondence up personally yourself, as president of Group Health? *A.*—No, sir.

Q.—Did you personally meet anybody at Homeopathic Hospital? *A.*—No.

Q.—You did have correspondence with Homeopathic? *A.*—Yes.

Q.—Did you receive from Homeopathic also advice that Dr. Selder's application had been disapproved there? *A.*—I think so.

Q.—Did you follow that up personally? *A.*—No, sir.

Q.—Did you find out from either of the three hospitals in any way the reason why Dr. Selders' application had been rejected? *A.*—No, I didn't.

Q.—Did you know for what privileges Dr. Selders had been making application in either of those three hospitals? *A.*—No, sir.

Q.—And you received, to your best recollection, a rather early reply from Emergency? *A.*—I think the reply was prompt.

Q.—And that did disclose to you the reason why Dr. Selders' application was rejected? *A.*—As I recall, Mr. Leahy, they quoted a paragraph in that letter from the by-laws which referred to the necessity for membership in the Medical Society.

Q.—And it also sets forth the fact that the by-laws had been adopted in 1936, did it not. *A.*—I think there was reference to that date.

. . . . . .

Q.—Now, how long was Dr. Selders with you after that time? *A.*—He remained until January 1939.

Q.—You asked for his resignation at that time? *A.*—Yes.

Q.—You were on the Board and president of Group Health at that time? *A.*—I wasn't president; I was on the Board.

Q.—By the way, when did you first go on the Board of Group Health? *A.*—In April 1937.

Q.—And when was it Dr. Brown was employed? *A.*—In June 1937; I think June 7th.

. . . . . .

Q.—Now, to return to Sibley Hospital, some time was it in June you had a series of letters interchanged between the two, with reference to the payment of some money for some patients of Group Health? *A.*—Yes. I will accept that date. We had two or three members in attendance at Sibley Hospital, and those patients were discharged. In the regular course of things we tendered our check in payment for the services there and in all three cases the checks were declined, and the correspondence grew out of the declination of those checks.

. . . . . .

Q.—Did anybody on the legal staff, any of those whose names were on the petition you filed, consult with you with reference to those letters? *A.*—No, sir.

Q.—Did any of them consult with you with reference to the letters written to the Sibley Hospital? *A.*—No, sir, not one.

Q.—Do you recall a letter which was introduced, addressed to Dr. Neill? *A.*—That I wrote.

Q.—Did you write that? *A.*—Yes.

Q.—Anybody consult with you about that letter? *A.*—I think I had some help in the formation of that letter.

Mr. Lewin:—Now, there are two letters. Identify the letter. Only one got in evidence.

Mr. Leahy:—Well, the letter that was received in evidence.

THE COURT:—You better show him the letter.

Mr. Leahy:—The letters are Exhibits 458 and 459. Do you remember the first letter you wrote to Dr. Neill?

The Witness:—Now, Mr. Leahy, there were two letters and I don't know which I wrote first. If I saw the letter I might tell you.

Mr. Leahy:—All right. We will get it.

Q.—While you are looking for that, I believe I forgot to ask you about George Washington Hospital. You wrote a letter also to George Washington, did you not? *A.*—I think that was included in the February 2nd letter.

Q.—And you received a notification from George Washington Hospital that they couldn't grant the privileges for Dr. Selders, for those for which he applied? *A.*—I think so.

Q.—Did you follow that up to find out why they could not do so? *A.*—No.

Q.—Did anybody for you? *A.*—Nobody that I ever heard of.

Q.—Now, I will show you what has been identified as Government Exhibit 458, dated March 21, 1938. Now, who was it helped you formulate that letter?

Mr. Lewin:—He has not said anyone helped him yet.

The Witness:—This is not the letter that I had the help on.

Q.—You wrote that without any help? *A.*—Yes.

Q.—Your recollection is that this is not the letter on which you had help? *A.*—The letter I had help on is the letter in response to Dr. Neill; somewhere about this time.

Q.—This one you wrote without any assistance from any member of the legal staff whatsoever? *A.*—Yes.

Q.—And this has reference to Dr. Price? *A.*—Yes, he was the doctor involved in that question.

Q.—How long was it that Dr. Price was on the staff? *A.*—Well, he came there shortly after we commenced operations and remained until some time in 1939.

Q.—Did he retire before you retired as president? *A.*—No, he retired after I retired.

Q.—Don't you remember that you had a controversy with Dr. Price while you were still president?

Mr. Lewin:—We object to it. It is beyond the scope of proper cross-examination; also immaterial.

THE COURT:—Yes, it would be unless it is for the purpose of refreshing his recollection.

By Mr. Leahy:

Q.—Do you recall when that occurred? *A.*—Now, if you characterize it as a controversy; I should say I had no controversy with him at any time. I had some discussion with Dr. Price.

Q.—Do you recall when that occurred? *A.*—Just toward the end of 1938.

Q.—Does that refresh your recollection now as to when Dr. Price retired? *A.*—No.

Q.—It does not? *A.*—No, because Dr. Price attended the meeting of the Board of Trustees, which was the last meeting I presided over as president, and I know he was on the staff long after that.

. . . . . .

By Mr. Leahy:

Q.—You knew, of course, that Sibley had a rule which required any doctor practicing in Sibley Hospital to be a member of the staff there? *A.*—Well, I presume they had that in common with every hospital in Washington.

Q.—You knew that before a doctor could practice he had to be a member of the staff? *A.*—Yes.

Q.—In the month of February you knew that Dr. Selders didn't have privileges in Sibley Hospital? *A.*—Right.

Q.—And some time before February 5th, you had sent a check to Dr. Taylor, hadn't you? *A.*—Yes.

Q.—And Dr. Taylor was then the superintendent, in charge of Sibley Hospital? *A.*—I think he was the president.

Q.—And you had received a letter, had you not, from Dr. Taylor, stating that Miss Tommie Lee Nix, on Sept. 4, 1937 was admitted "to this hospital on service of Dr. Rush Conklin; later she was transferred to the service of Dr. Little, and was then operated on by Dr. Cobb. On her admission card responsibility for the payment of her bill is "assumed by" over the signature of James R. Nix. Do you know who he was? *A.*—I assume her brother.

Q.—"And we look to him for settlement of this account"? (showing document to the witness). *A.*—Right.

Q.—That is Dr. Taylor's statement to you as the reason for returning the check? *A.*—Yes.

Q.—Did you have any correspondence from Dr. Taylor before in the case of anyone who went to the hospital? *A.*—No, sir.

Q.—Had anybody at your request? *A.*—No, sir.

Q.—So that Miss Nix had gone into Sibley, so far as Dr. Taylor was concerned, from his letter, without any knowledge on the part of the hospital authorities that Group Health Association was going to hold itself responsible for payment of the bill? *A.*—I don't understand that to be the situation at all.

Q.—Didn't you understand when you were told that Mr. Nix was going to be held responsible for the bill that the hospital was not looking to Group Health for its payment? *A.*—I understand that statement, but I don't agree with it.

Q.—So you sent the check back again, didn't you? *A.*—I sent it back two or three times.

Q.—Why didn't you accept Dr. Taylor's statement, as contained in his letter, that the hospital was looking to Mr. Nix for the payment of the bill? *A.*—Because I wanted to establish the fact that we could pay that bill with our own check.

Q.—That was the purpose of that? *A.*—Yes.

Q.—Did you have some correspondence with Mr. Paul B. Cromelin about that? *A.*—Not about that question; I wrote him a letter.

Q.—You knew Mr. Paul B. Cromelin was counsel for the Sibley Hospital, did you not? *A.*—I didn't know that.

Q.—Did you know he was an attorney? *A.*—I knew he was an attorney when I got his letterhead which indicated it.

Q.—You hadn't talked with him over the telephone about this matter? *A.*—No, never spoke to him.

Q.—Do you know whether anybody on behalf of G. H. A. had spoken to him? *A.*—Not that I know of.

Q.—When you got his letter which indicated that he was an attorney, did you try to get hold of him? *A.*—No.

Q.—Why were you so insistent on the hospital accepting this check, when you knew that the credit had been extended to Mr. Nix and not to Group Health. *A.*—Because, Mr. Leahy, we felt we had the right to discharge the liability, which we regarded as ours, and we wanted to establish the fact that we had full right to have that hospital accept our check, just as other hospitals had.

Q.—What other hospitals had? *A.*—Every other hospital that we sent our check to.

Q.—Then other hospitals did accept your check? *A.*—Yes.

Q.—That was the only hospital you had a difference with? *A.*—Yes.

Q.—Why was it that you didn't get the cash in the first place as you did finally? *A.*—We wanted to establish that we had a check drawn for this thing, I think you will agree, a check is the best evidence of payment of a bill.

Q.—Did you doubt that the Sibley Hospital would mark the bill "Paid" if it got cash? *A.*—We didn't care how they marked the bill. What we wanted was to have their endorsement on our check.

Q.—Was it that you were just trying to build up the record against Sibley, who wouldn't accept your check? *A.*—No, nothing in the world like that. I may say that during this time that this correspondence was going on we received a solicitor from Sibley for a contribution.

Mr. Leahy:—Well, that isn't necessary to go into that.

Mr. Kelleher:—Why not. Let him answer.

Mr. Lewin:—He says that during that time Sibley sent a solicitor there.

The Witness:—We were simply trying to establish the validity of our tendering a check and have them accept it.

Q.—You were trying to make Dr. Taylor at Sibley receive your check? *A.*—Yes.

Q.—And he had told you some one else was responsible and you knew that the fact of such responsibility was evidence by this notation on the card at the time the patient was admitted. Dr. Taylor had so informed you? *A.*—That is what he said.

Q.—Do you recall now how many letters you wrote in that regard? *A.*—Two or three.

Q.—You didn't get any advice from anybody about that? *A.*—None whatsoever.

Q.—Never talked with Mr. Russell about that? *A.*—No.

Q.—Or with any one of your legal staff? *A.*—No.

Q.—Who was it suggested "legal tender"? *A.*—What do you mean by "legal tender"?

Q.—Legal tender. *A.*—I thought of it as a final solution of the question. We didn't want to keep on sending this check back and forth indefinitely.

Q.—That was the first reference to that, February 24—February 5, instead of February 24—this was sent, and then you followed that up with your letter of February 18, Exhibit 418, and you said in your letter in response to Dr. Taylor's statement that he considered the check was evidently sent in error, that you wanted him to know that there was no mistake on your part in transmitting the check in question. Is that so? *A.*—Yes.

Q.—So you wrote him this letter in which you said "Under the provisions of the by-laws of Group Health, Inc., Miss Nix is entitled to have provided to her hospitalization, when such is necessary. Miss Nix, having received hospitalization in your institution for the dates mentioned is therefore entitled to have the cost of that hospitalization paid for by Group Health, Inc.

"Your attention is invited to the fact that the stub which contains the notation referred to is not in any sense a part of the body of the check. The stub is provided only for the information of the payee as to what the check is entitled to cover. In depositing the check, if you so desire, the stub, of course, may be detached before the check is deposited.

"We are therefore returning the check to you and ask that it be deposited in the usual course."

Now, did he answer that letter? *A.*—I think he sent the check back again.

Q.—Under date of February 21, is that right? *A.*—Yes.

Q.—And again, didn't he call your attention to the fact that she signed her own card, and that card has the name of her brother, James R. Nix, as the person who would be responsible for her bill? *A.*—Yes, but we didn't consider him responsible for the bill; we considered ourselves responsible for it.

Q.—So you were going to compel Sibley to accept your check, if you possibly could? *A.*—Not compel them, get them, if we could.

Q.—Then you sent them a check back a third time? *A.*—We finally settled it.

Q.—Why didn't you send the cash in the first place? *A.*—We wanted a record to show that we had paid the bill.

Q.—What final record did you get out of it? *A.*—None.

Q.—Didn't you get a record that you paid cash? *A.*—We didn't from Sibley Hospital.

Q.—Didn't you have a Group Health record of the fact that you had paid this bill? *A.*—We have a record in our cash book, but we have no evidence from Sibley that we paid the bill.

Q.—Well, you have the record that the bill is paid, do you not? *A.*—We have a record that we gave the money to somebody at Sibley, but we have never received from them a receipt.

Q.—Did you ask for a receipt? *A.*—We certainly did.

Q.—Who was it that made the payment? *A.*—My secretary, Ben Jones.

Q.—Is he still in Washington? *A.*—I don't know.

Q.—You haven't seen him since you came here this time? *A.*—I haven't seen him for two or three years.

Q.—Now, didn't you ever talk with Dr. Taylor as to why he didn't want to take them? *A.*—I never talked with him in my life.

Q.—You didn't know that Mr. Cromelin had advised Dr. Taylor to write you as he did? *A.*—I didn't, and I didn't care what advice he had given him.

Mr. Lewin:—I object to this line of questioning. It is just redundant and time-consuming.

THE COURT:—I think it has been covered.

. . . . . .

By Mr. Leahy:

Q.—I just want to know, he said the general topic, the conversation took a half an hour. What was it you were discussing? *A.*—I will tell you one thing. I asked Mr. Mitchell and repeated it three times if it were a fact that every member of the staff of Emergency Hospital was a member of the District Medical Society, and he replied each time in the affirmative; at the same time I knew that was in error. That is why I asked that.

Q.—What was the error? *A.*—It was in the case of Dr. McCready. He was on the staff, but he was not a member of the Medical Society.

Q.—How do you know he was on the staff? *A.*—Because he showed me a letter appointing him to the staff a week before that. That was in early spring of 1938, when he was serving as a refractionist for Group Health.

Q.—That is interesting; then you did have a man from Group Health on the Emergency Hospital staff? *A.*—No, he was on a fee basis for us. We paid him $5 per case.

Q.—Do you mean that Dr. McCready was not employed by you? *A.*—I mean he was not a member of our staff.

Q.—Well, we won't quibble about words: was he under employment by Group Health? *A.*—He was employed to refract eyes at $5 a case during that emergency.

Q.—Employed by whom? *A.*—Group Health.

Q.—And at that time he was a member of the staff of Emergency Hospital? *A.*—Yes.

Q.—Did you tell Dr. Mitchell that you did have a member of your association on the hospital staff there? *A.*—No.

Q.—You didn't: why? *A.*—Because he was not a member on our staff.

Q.—You didn't consider him a member of your staff? *A.*—No, neither did we consider any physicians we employed on a fee basis.

Q.—Did you tell Dr. Mitchell he was on a fee basis with your staff? *A.*—I never mentioned Dr. McCready to him.

Q.—Did you know he was not a member of the District Medical Society? *A.*—He told me he was not.

Q.—Did you know of your own knowledge that he was not? *A.*—No, sir.

Q.—Then your information that Dr. Mitchell was in error is based on something he told you? *A.*—I think he is the best evidence. He ought to know.

Q.—Did you ever make inquiry of the District Medical Society to determine that? *A.*—I didn't; I accepted his word.

Q.—Were there any other physicians you had on a fee basis who had staff privileges? *A.*—There may have been. I remember Dr. Eckelby as one, and Dr. Warfield, who I think is a defendant in this case. And there was Dr. Ledbetter. We didn't inquire whether they were members of this, that or the other thing. They did their work and we paid them.

Q.—About how many did that work? *A.*—I should say there were six or eight, perhaps a dozen of them.

Q.—And that was work for which the clinic was not equipped? *A.*—No, sir, we were equipped for that work.

Q.—Who would do the work that Dr. Ledbetter was engaged to do? *A.*—I couldn't say.

Q.—Think it over; you were president for a year and a half. *A.*—I could think it over but I wouldn't know.

Q.—You are familiar with the work the various surgeons or physicians did, are you not? *A.*—You are asking me to tell you who on the staff could do the work that Dr. Ledbetter did. I don't know. I didn't get into this medical question at all.

Q.—You said you were obliged to hire Dr. Ledbetter? *A.*—We were.

Q.—Now, isn't Dr. Selders the only surgeon you had? *A.*—Yes, for general surgery. Dr. Halstead is also a surgeon, for minor surgery.

Q.—Did you have anybody for orthopedic work? *A.*—Not that I know of.

Q.—What kind of work did Dr. Ledbetter engage in? *A.*—I don't know. All I know is we paid him for services performed, and I know that because I signed the check.

Q.—All you know is you paid the bill to various doctors? *A.*—Yes, that is all.

RE-DIRECT EXAMINATION

By Mr. Lewin:

Q.—I hand you the roster of the Medical Society members of the District of Columbia, which is Exhibit 32, and ask you to look that over; and ask you to see if you can find the name of Dr. McCready on that list?

Mr. Leahy:—It speaks for itself.

Mr. Lewin:—It speaks loudly against your point.

The Witness:—I looked under the "M's". I don't find his name there. Do you want me to look all the way through it?

By Mr. Lewin:

Q.—No. After you had your conversation with Mr. Rogers of the Casualty Hospital, you say at that meeting Mr. Rogers told you that they had a rule in effect that they could not accept on their courtesy staff non-members of the District of Columbia Medical Society? *A.*—He said it was first of the by-laws.

Q.—After that didn't he tell you to submit another application to Dr. Selders? *A.*—You mean verbally, or by correspondence, or by what? I think there was a letter later on in which he either enclosed an application or asked for it.

Q.—I show you Exhibit 403 and ask you if this is Dr. Rogers' letter to you of Aug. 2, 1938. *A.*—It is.

Q.—And didn't he say in that letter if Dr. Selders will submit a further application that it will receive consideration? *A.*—Yes.

Q.—Is there anything in that last communication indicating that there was some iron-clad rule which would prevent the doctor from receiving staff privileges notwithstanding he was not a member of the Society?

Mr. Leahy:—I submit it speaks for itself.

The Witness:—There certainly isn't.

TESTIMONY OF MARY FRANCES STUART MAURY.

DIRECT EXAMINATION

By Mr. Lewin:

Mary Frances Stuart Maury said that in 1937 she was Miss Stuart. In November 1937 she was laboratory technician for Group Health. She was graduated with an A.B. degree, majored in science, after which she took a year's course at the University of Virginia Medical School as a laboratory technician. In November 1937 she was taken ill.

Q.—Will you tell the jury the circumstances of your becoming ill? *A.*—I was awakened in the morning about 6:30 with severe abdominal pain, and I got up out of bed and fainted.

Q.—Do you know how long you remained unconscious? *A.*—No.

Q.—Could you tell us what you did on regaining consciousness? Did you ask for a doctor? *A.*—Miss Lewis, who was the chaperon at the house where I lived had called and—

Mr. Leahy (interposing):—We object to the conversation.

By Mr. Lewin:

Q.—All right. My question was, did you ask for a doctor when you came to?

THE COURT:—A better question would be to ask her if she finally got a doctor.

The Witness:—Shall I answer that?

Mr. Lewin:—Yes.

The Witness:—Yes, Miss Lewis had called her personal physician, Dr. Birdsall. After he had already been called, Miss Lewis asked me about a doctor and I specified Dr. Allan E. Lee, on the staff of Group Health.

By Mr. Lewin:

Q.—And did Dr. Lee come there? *A.*—Yes.

Q.—How soon after you asked for him would you say? *A.*—Very soon.

Q.—And did he make an examination of you? *A.*—Yes.

Q.—What did he do as a result of that examination? *A.*—He recommended that I be taken to the hospital.

Q.—Did you suggest which hospital you preferred? *A.*—Yes.

Q.—Which one was it? *A.*—Garfield.

Q.—Were you taken to the hospital? *A.*—Yes.

Q.—Were you taken there in an ambulance? *A.*—Yes.

Q.—And about what time would you say you arrived at the hospital? *A.*—I think it was around ten.

Q.—Did he tell you that an operation would be necessary?

Mr. Leahy:—I object to what he told her.

THE COURT:—She may answer that.

Mr. Lewin:—Did he tell you whether any operation would be necessary?

The Witness:—He thought before I left home, he told me before I left home an operation would be necessary.

By Mr. Lewin:

Q.—And did you engage a surgeon or leave that to him? *A.*—I left it to him.

Q.—And did you know who the surgeon would be when you left your house to get in the ambulance to go to the hospital? *A.*—No.

Q.—After you arrived at the Garfield were you taken to a room and put to bed? *A.*—Yes.

Q.—And then did a doctor come in to see you? *A.*—Yes.

Q.—When, with reference to the time you arrived at the hospital? *A.*—It seemed rather long to me; I don't know exactly how long it was.

Q.—Was any treatment given to you while you were awaiting your doctor? *A.*—Not that I recall.

Q.—When the doctor finally came, who was he? *A.*—Dr. Schoenfeld.

Q.—Is that Dr. Herbert H. Schoenfeld? *A.*—Yes.

Q.—And did he then give you any treatment? *A.*—I had an injection before I was taken to the operating room.

Q.—Yes, but did he give you any treatment after examining you? *A.*—No.

Q.—Did he give you that treatment after he came back? *A.*—I don't recall.

Q.—How long after he left the room was it before he returned? *A.*—I imagine it was around an hour. I am very vague about the time.

Q.—And who came in with him, if anybody, when he returned? *A.*—An assistant. I don't recall his name.

Q.—And were you later operated on? *A.*—Yes, sir.

Q.—Who performed the operation? *A.*—I was told Dr. Schoenfeld.

Q.—Can you tell us about when the operation took place? *A.*—Sometime after noon.

Q.—Would you say it was in the early afternoon or the late? *A.*—Early afternoon.

Q.—You would say it might have been as early as 12:20? *A.*—I had no idea of the time.

CROSS EXAMINATION

By Mr. Leahy:

Q.—I have only this one question. If it should become necessary, would you be willing to let Dr. Schoenfeld tell the Court and jury what he did that day? *A.*—Yes.

Q.—I am going to tell you why: you have a right under the law to refuse to permit a doctor to tell of his treatment of you.

Mr. Lewin:—It has already been covered by a written waiver, which I hold in my hand, signed by Mrs. Maury.

Mr. Leahy:—I just wanted to know, if we called him, would you object or would you be willing to have him testify. *A.*—I would be willing.

Q.—You were not a member of Group Health? *A.*—No.

Q.—You were just an employee? *A.*—Yes.

Mr. Lewin:—As a matter of fact, is this your signature to a waiver permitting Dr. Schoenfeld to testify concerning your operation. *A.*—Yes.

TESTIMONY OF DR. ALLEN E. LEE

DIRECT EXAMINATION

By Mr. Kellcher:

Allen E. Lee said he is a Doctor of Medicine, and limits practice to diagnosis and internal medicine. He obtained his doctor's degree at the University of Michigan in 1930. Then he took some postgraduate work at Ohio State until 1932. In 1931 he was at Cleveland; in 1932 at Columbus. He was chief resident at the University of Ohio. It was in the University of Ohio State Hospital, or Starling-Loving. Then he went back for some time to Ann Arbor and came to practice in Washington in 1934. He became associated with the Medical department at Georgetown as instructor in medicine.

Q.—While you were with Georgetown did you also have any classes for nurses? *A.*—I had, I think, for one year, a course in Materia Medica with the nurses there. I started a course with them; and then I taught some classes at Garfield Hospital.

Q.—When you came to Washington did you join the Medical Society of the District of Columbia? *A.*—I joined it in 1934 or 1935, I think, at the time I started practicing.

Q.—Now, Dr. Lee, did you join the staff of G. H. A. or Group Health Association, Inc., in the latter part of October,

1937? *A.*—Well, I believe I did. I am not exact about the date, but I believe I joined the clinic in 1937, the latter part of the year.

Q.—Were you on the staff of Group Health Association when the clinic opened up on I Street? *A.*—When it opened I was affiliated with the clinic.

Q.—Dr. Lee, do you know, or did you know, Miss Mary Frances Stuart? *A.*—Yes, sir.

Q.—Was she a patient of yours on Nov. 18, 1937? *A.*—I don't recall the exact date, but she was a patient of mine shortly after I was with the clinic.

Q.—Will you describe to the jury the circumstances surrounding your treatment of her?

Mr. Lewin:—You might care to see this waiver of Mrs. Maury.

THE COURT:—The doctor may understand that he is at liberty to testify.

The Witness:—Then I can refer to her record, I believe?

THE COURT:—Yes.

By Mr. Kelleher:

Q.—You are referring to a record which you made contemporaneously with the treatment? *A.*—Yes. It is my custom to keep a record of my patients in private practice. I saw Miss Mary Stuart on Nov. 18, 1937. I have a record here of the time. It was at 7:30 a m.

Q.—In the morning? *A.*—Yes; 7:30 in the morning. After going over her carefully I made a diagnosis of one of two possibilities which I indicated as an acute appendix, possibly rupture, or possibly a ruptured ovarian cyst, with hemorrhage. That was my working diagnosis at that time. She was in shock, surgical shock, and had a surgically acute abdomen.

Q.—What do you mean by surgical shock? *A.*—It is rather a complex term to explain in layman's language. It means a condition in which a patient's bodily functions have more or less collapsed; the circulation, and possibly involving blood pressure and heart function, cerebral function.

Q.—Is it a serious condition? *A.*—We consider it serious.

Q.—May a patient die from shock alone? *A.*—It depends on the type of shock. A shock is usually considered a critical thing.

Q.—Take the type of shock she was suffering from: was that serious enough to induce death? *A.*—Well, ruptured internal viscus produces shock. It does not necessarily produce death within a short length of time. It is not as bad as a traumatic shock or a shock following an accident.

Q.—Will you tell us what instructions you gave for the care of Miss Stuart? *A.*—As I recall it, referring to the record here, I got in touch with Dr. Brown, who was director of the clinic. I simply referred the matter to him, because Miss Stuart was a member of the personnel, and he stated—

Mr. Leahy:—I object

THE COURT:—Yes. I would not go into the conversation.

By Mr. Kelleher:

Q.—Did you order Miss Stuart sent to the hospital? *A.*—I put an order in to have her transmitted to the hospital by ambulance as soon as possible, after I spoke to Dr. Brown.

Q.—To what hospital? *A.*—Garfield Hospital.

Q.—Did Miss Stuart suggest any surgeon? *A.*—Miss Stuart was more or less in a semistuporous condition at the time.

Q.—I do not think I asked you this. Did you conclude, as a result of your diagnosis, that an operation was necessary? *A.*—Well, my opinion was that surgery was indicated as soon as possible.

Q.—And you are not a surgeon, of course. *A.*—No, sir.

Q.—As a result of your conversation with Dr. Brown was a surgeon selected? *A.*—Following Dr. Brown's suggestion she voiced a request for a surgeon, and that surgeon was called.

Q.—Who was that surgeon? *A.*—Dr. Schoenfeld.

Q.—Who called Dr. Schoenfeld? *A.*—I did.

Q.—What did you tell him? *A.*—I described the problem involved and told him I thought the patient was in serious condition and I would appreciate his seeing the patient as soon as possible.

Q.—Did you tell him what your diagnosis of the patient was? *A.*—I told him exactly in the words that I have just described in the working diagnosis.

Q.—Will you tell us what transpired after you had contacted Dr. Schoenfeld? *A.*—I talked to Schoenfeld and was to meet him at some designated time, which I do not recall at this moment, as early as possible, at the hospital.

Q.—Continue. *A.*—When I arrived there—I don't recall just what time it was—I met Dr. Schoenfeld coming down the hall toward me, and of course my first question was if he had seen the patient, and from his remarks I gathered that perhaps—

Mr. Leahy:—I object to any conversation.

By Mr. Kelleher:

Q.—Tell us what you said to Dr. Schoenfeld and what he said to you.

Mr. Leahy:—I object to that.

Mr. Kelleher:—May we approach the bench on this, your Honor?

THE COURT:—Yes.

(Counsel for both sides approached the bench.)

. . . . . .

By Mr. Kelleher:

Q.—Did Dr. Schoenfeld operate upon Miss Mary Frances Stuart? *A.*—Yes, sir.

Q.—Were you present when the operation occurred? *A.*—I was there when the operation occurred.

Q.—What did the operation show as to her illness? *A.*—It showed cystic tumors of both ovaries and tubes, with hemorrhage.

Q.—With hemorrhage? *A.*—Yes, The right ovary was ruptured, accompanied by hemorrhage.

Q.—Is that a serious condition, Doctor? *A.*—Well, it is not such that it will cause death immediately. It is serious, because it is a ruptured viscus.

Q.—Was the matter of the hemorrhage serious? *A.*—Well, if there was the amount of hemorrhage when the patient was on the operating table one would not say it was serious, but clinically a ruptured viscus is usually considered a serious diagnosis.

Q.—Doctor, prior to your joining Group Health Association did you notify the Society that you intended to resign? *A.*—I think I did.

Q.—Do you know what date that was? *A.*—No, sir.

Q.—I show you what has been introduced in evidence as U. S. Exhibit 41 and ask you if that is your letter of resignation to the Society, dated Oct. 30, 1937? *A.*—Yes, sir.

Q.—Do you recall, after you resigned, whether you were cited by the Compensation, Contract and Industrial Medicine Committee of the Society? *A.*—Well, I don't know what you mean by that word "cited."

Q.—Will you tell what happened? *A.*—I received a letter stating that—calling my attention to the fact that I was to be taken up before the committee, or that my standing was to be taken up before the committee, in consideration of the contract which I was to have had with Group Health.

Q.—Do you know what date that was? *A.*—I don't recall the date.

Q.—I show you Exhibit 39 and ask you whether that is the letter which you received from the defendant Hooe, dated Nov. 2, 1937? *A.*—Yes, sir; that is it.

Q.—After you had received this letter, Exhibit 39, did you talk on the telephone with the defendant Hooe? *A.*—I recall having several conversations with him on the telephone.

Q.—Did you discuss with him the matter of your resignation from the Society? *A.*—I believe I notified him that I had sent a letter of resignation in, and that therefore perhaps I was not subject to any call by his committee.

Q.—And what did the defendant Hooe say? *A.*—I don't recall that.

Q.—After you had received this notification from the C. C. & I. M. Committee, did you receive any other notification to appear before the Executive Committee of the Medical Society? *A.*—I think I did.

Q.—Did you have any hearing before the C. C. & I. M. Committee? *A.*—Well, I recall having no hearing until the very last night, at which time I enclosed my resignation from Group Health.

Q.—That was after the hearing of the Executive Committee started? *A.*—Yes, sir.

Q.—You say you had no hearing before the C. C. & I. M. Committee before the first night of the hearing before the Executive Committee? *A.*—That was the only hearing I recall being in. It was the Executive Committee, I believe, in joint session with the Contract Committee.

Q.—I want to be sure. What is your answer to my question as to whether or not you had any hearing before the C. C. & I. M. Committee before Dec. 6, 1937, the date of the first meeting of the Executive Committee? *A.*—Is that the date of the Executive Committee hearing?

Q.—Yes. *A.*—I did not.

Q.—Did you attend the first hearing of the Executive Committee on December 6? *A.*—Well, I won't say about the date, but I did attend the first hearing of the Executive Committee.

Q.—What occurred at that hearing? *A.*—Well, it was a hearing at which I appeared to explain, as I recall now, the contract at issue between me and Group Health.

Q.—When you say you appeared, what do you mean? Did you testify? *A.*—I was called before the committee to explain a contract that I was supposed to have had between myself and Group Health Association.

Q.—Who examined you before the committee? *A.*—Well, now, I don't understand that.

Q.—Who asked the questions? *A.*—It seemed that the entire group asked questions.

Q.—Was the committee represented by attorneys? *A.*—Yes, sir.

Q.—Did any attorney question you? *A.*—Yes. I believe I was questioned by attorneys.

Q.—Who was the attorney? *A.*—Offhand, I recalled Mr. Hoover doing a lot of questioning that evening.

Q.—Do you recall Mr. Leahy, this gentleman over here (indicating)? *A.*—I believe he was there that evening, but I don't recall his questioning me.

Q.—After you had testified on December 6, and before Friday, December 10, did you see the defendant Hooe or talk with him over the telephone? *A.*—I believe I had one conversation with him on the telephone between those two dates, the first one being the date at which I appeared before the committee.

Q.—That is, December 6? *A.*—I believe that was the first date; and the second date being the night of my resignation. Is that correct?

Q.—That would be December 10. *A.*—December 10. I had a telephone conversation with him, during which he stated that proceedings would be dropped or that my standing would be unaffected in the Society should he have a copy of my resignation by a certain time that evening.

Q.—Resignation from what? *A.*—Group Health.

Q.—Did he call you or did you call him? *A.*—I believe I called him.

Q.—Did you attend a meeting at the Medical Society Building on December 10? *A.*—I attended as a member in good standing of the Society; yes. I enclosed my resignation from Group Health.

Q.—Will you tell us how and where you announced your resignation? *A.*—I don't recall the details, except that on that evening I appeared as per request to continue with the hearing, and my resignation had already been submitted to Dr. Brown. A copy of it had been sent, I believe, to Dr. Hooe. And I met Dr. Hooe, who requested that I stop in before the Contract Committee and that he would announce that all proceedings would be dropped.

Q.—Did you go in before the C. C. & I. M. Committee? *A.*—Yes; I believe it was that committee—in one of the ante rooms of the Medical Society.

Q.—Did Dr. Hooe make the announcement which you suggest? *A.*—I recall that he did.

Q.—What did he say, in substance? *A.*—He simply stated that proceedings were dropped and that my standing was unaltered, in accordance with the fact that he had notice of my resignation from Group Health, or words to that effect. I can't give you the exact wording.

Q.—Did you notify Dr. Brown by letter that you had resigned from G. H. A.? *A.*—I gave Dr. Brown a letter personally.

Q.—Was that on December 10, the night of the second hearing? *A.*—I think it was on the afternoon of the same day.

Q.—I show you Exhibit 60 and ask you whether or not it is the original or a carbon copy of your resignation which you said you gave Dr. Brown? *A.*—That is a copy of the letter, I believe, that I gave Dr. Brown.

Q.—Did you enclose a copy of the letter to Dr. Hooe, dated Dec. 10, 1937? *A.*—Yes, sir. That is the original.

Q.—Now, Dr. Lee, did you receive a communication from the defendant Hooe notifying you that you were a member in good standing, in view of your resignation from Group Health Association? *A.*—Well, I don't recall whether I received a memorandum to that effect.

Q.—May I show you Exhibit 61 and ask you whether you received the original of that document. *A.*—I believe I did get the original.

CROSS EXAMINATION

By Mr. Leahy:

Q.—With reference to Miss Stuart, do you recall about what time it was that you first received word to go to her? *A.*—I don't recall the exact time. I have a note on her chart that I saw her about 7:30 in the morning.

Q.—And then you got in touch with Dr. Brown? *A.*—I got in touch with Dr. Brown first.

Q.—And Dr. Brown suggested the name of Dr. Schoenfeld? *A.*—Yes, sir.

Q.—Then you got in touch with Dr. Schoenfeld? *A.*—Yes.

Q.—Have you any idea what time Miss Stuart got to the hospital? *A.*—I have no idea, but there must be a record on her hospital chart.

Q.—Do you recall the time you got to the hospital? *A.*—Well, I must have gotten there—I don't recall exactly—

Q.—Some time before 12 o'clock? *A.*—Oh, yes.

Q.—Would you say it was around 10 o'clock? *A.*—It is difficult for me to state the exact time, so I would not commit myself on that. I recall coming into the hospital at such time as Dr. Schoenfeld was coming down the hall, and we both met. My impression was at the time that he had seen the patient and knew something about her; and from then on we had our contact.

Q.—Some time has to elapse in the preparation for an operation? *A.*—Yes, sir.

Q.—The operating room has to be gotten in order; the patient also has to be gotten in order for the operation? *A.*—Yes.

Q.—Do you recall what time the operation was performed? *A.*—I have the time of it on my chart.

Q.—Will you tell us that? *A.*—I have here a note that she was operated on at 11:30 a. m.

Q.—Is that—well, you said you did not know about what time you got to the hospital. But she was operated on at that time? *A.*—Yes.

Q.—You found that generally your diagnosis was correct, did you not? *A.*—Yes, sir.

Q.—Was there a good deal of hemorrhage? *A.*—I don't know what the surgical note states, but my note states that there was hemorrhage in the pelvic cavity. As to the amount I do not have a note here; but as I recall, she had hemorrhage of such volume as would have endangered her life.

Q.—Just a couple of questions about those two dates of December 6 and December 10. You appeared at the first hearing which was held December 6, did you not? *A.*—Yes, sir.

Q.—At that time you tendered your resignation, effective as of November 1; is not that right? *A.*—I believe that letter is dated.

Q.—That was dated October 30? *A.*—Yes.

Q.—In other words, at that time, October 30—am I right on that October 30?

Mr. Kelleher:—That is correct.

By Mr. Leahy:

Q.—On October 30 you had made up your mind to resign from the Medical Society? *A.*—Yes.

Q.—And I presume you came to your conclusion, did you not, after deliberation and after weighing the pros and cons? *A.*—I arrived at that conclusion feeling that perhaps I ought to avoid a lot of time in controversy that might have elapsed later.

Q.—Did you discuss the matter among your friends or take advice on the matter before you came to your conclusion? *A.*—That conclusion was made unadvised.

Q.—Your own good judgment? *A.*—My own good judgment.

Q.—On December 6 had you in the meantime recalled that resignation in any way? *A.*—I recall that I had probably made an attempt at recalling it, since there was no action carried out on that letter of resignation.

Q.—Do you recall in what shape you had attempted to recall it? *A.*—I believe a letter was sent to that effect.

Mr. Leahy (addressing Mr. Kelleher):—Have you got that letter?

Mr. Kelleher:—Yes (handing a paper to Mr. Leahy).

By Mr. Leahy:

Q.—I now show you a letter, Doctor, which is dated Nov. 11, 1937, and it is Exhibit 43. Do you remember writing this? *A.*—Yes, sir.

Q.—Was that your dictation or somebody else's? *A.*—That was my dictation.

Q.—At whose suggestion? *A.*—Well, after having had a conference as to what we ought to do about the letter of resignation.

Q.—With whom did you confer? *A.*—Offhand, at this time I don't recall. I believe Mr. Penniman and Mr. Zimmerman probably talked it over.

Q.—Did you have any legal advice? *A.*—There might have been some legal counsel there with us at the time.

Q.—Did Mr. Russell advise you about this letter? *A.*—I don't recall exactly.

Q.—But you do recall some lawyer there? *A.*—There were lawyers there with us at the time.

Q.—Did the lawyers make the set-up of the letter? *A.*—Well, I think perhaps that letter was to a great extent my own suggestion.

Q.—Did the thought come from this conference that you had with Mr. Penniman, Mr. Zimmerman and the lawyers? *A.*—I cannot say that now. We all talked it over.

Q.—Do you recall whether any of the lawyers for Group Health were present at the hearing on December 6? *A.*—I believe we had quite an imposing array of lawyers there.

Q.—You had some four or five, did you not? *A.*—Yes.

Q.—You had Mr. Russell there? *A.*—Mr. Russell.

Q.—And Mr. York? *A.*—I believe Mr. York was there.

Q.—Any others that you recall? *A.*—I don't recall the names.

Q.—But there was an imposing array? *A.*—Yes.

Q.—It looked a bit like the Supreme Court around there at that time, did it not? *A.*—With all the Executive Committee members and the lawyers it looked like it.

Q.—Then the next hearing was on December 10, was it not? *A.*—December 10.

Q.—And were the same lawyers present on December 10? *A.*—Practically the same crowd was there.

Q.—Had you attended any sort of a trial before? *A.*—What do you refer to? A trial outside—

Q.—Where you testified in court? *A.*—Yes; I have testified before.

Q.—And the Executive Committee was sitting there as a group of judges, and the lawyers on one side would ask questions and the lawyers on the other side would ask questions? *A.*—They were sitting there, it seemed to me at the time, as a combination of judge, lawyer, district attorney—a pretty complete group of itself. They all seemed to ask questions, which of course I felt was a little bit—

Mr. Kelleher:—You mean, the committee?

The Witness:—Yes.

By Mr. Leahy:

Q.—Were the lawyers for Group Health also asking questions? *A.*—I believe they asked questions, but we did not have much opportunity to explain.

Q.—Were they asking questions? *A.*—Yes.

Q.—And the lawyers for the committee also were asking questions? *A.*—Yes. Mr. Hoover asked plenty of questions.

Q.—And there were arguments on both sides, pro and con? *A.*—Yes. It got pretty warm.

Q.—And that was the meeting on December 10, was it? *A.*—That was the first meeting. I don't know what the date was.

Q.—You did not attend the December 10 meeting at all? *A.*—No, only as an observer, which was a little bit cooler.

Q.—Did you also consider, on September 8 or 9, when you tendered your resignation, the fact that you should resign from Group Health? Was that your deliberate judgment? *A.*—The resignation from Group Health was my own deliberate judgment.

Q.—Did you take advice from any lawyers in reference to that? *A.*—No. I arrived at that conclusion myself.

Q.—You weighed the pros and cons in the matter, did you? *A.*—It was my own conclusion.

Q.—And you came to the conclusion that you ought to resign; is that right? *A.*—I arrived at the conclusion because it seemed to me that I was wasting a good bit of time in a controversy that I could devote to my own practice of medicine, taking care of sick folks.

Q.—Did you weigh that thought over against the experience also that you had had in Group Health? *A.*—Well, I don't know what you have in mind; but it seemed to me that I was—I arrived at the conclusion that perhaps the private practice of medicine in which I was devoting most of my time at that time was for me much more preferable.

Q.—Much more preferable than the practice you found in Group Health? *A.*—I had only spent two or three hours a day at Group Health, anyway, and it seemed to me that the controversy was getting so that it would usurp a good deal of my time that I had to devote to sick people.

Q.—Do I understand correctly, then, Doctor, that you took into consideration what your experience had been in the practice at Group Health, over against your practice in the private practice of medicine, and that you preferred to pursue your private practice of medicine, and that therefore you resigned? *A.*—Well, I will put it in my own words, if you don't object.

Q.—I would be glad to have them. *A.*—I arrived at the conclusion to resign from Group Health because I felt I was wasting a good bit of time that should be devoted to the care of sick people, rather than to be involved in a controversy between Group Health and the Medical Society.

Q.—You could have devoted your entire time with Group Health if you wished, could you not? *A.*—I could have; yes. But it seemed to me that private practice was much more preferable.

Mr. Leahy:—That is all.

RE-DIRECT EXAMINATION

By Mr. Kelleher:

Q.—When you say that you preferred to spend more time a day in private practice, do you mean that you would have preferred private practice in the absence of this controversy between Group Health Association and the Society? *A.*—That is quite a hypothetical question, because actually there was no such situation.

Q.—All right. Let me put the situation, then. Was the controversy between Group Health Association and the Medical Society the cause of your resignation from Group Health Association? *A.*—Yes; I think it was the cause.

Mr. Kelleher:—That is all.

RE-CROSS EXAMINATION

By Mr. Leahy:

Q.—Did not your desire to devote your life to private practice, Doctor, enter into your decision as you have stated? *A.*—I just stated that a moment ago. Yes; that was a factor in my arriving at the conclusion to resign.

Q.—Then you took everything into consideration when you made up your mind? *A.*—That is right.

Q.—And you had the preference to private practice rather than Group practice—

Mr. Kelleher:—Oh, now; wait a minute.

Q. (Continuing)—if there was any controversy existing about Group practice? *A.*—Yes. I had a preference for private practice in preference to group practice, should there exist any controversy about the group practice type of medicine.

RE-DIRECT EXAMINATION

By Mr. Kelleher:

Q.—If there had been no controversy would you have resigned from Group Health when you did? *A.*—I said that that was a hypothetical question. If there had not been any controversy I might have still felt that some medical opinion ought to give the group type of practice support.

TESTIMONY OF SARAH ABBOTT

DIRECT EXAMINATION

By Mr. Kelleher:

Miss Sarah Abbott lives in Trenton, New Jersey. She was in Washington in 1937, employed in the Home Owners' Loan Corporation.

Q.—Were you a member of Group Health Association? *A.*—I was; one of the original members.

Q.—Were you in an automobile accident in January 1938? *A.*—Yes; on the 26th of January.

Q.—Will you describe that to the jury, please? *A.*—It was about 10 in the evening, and in crossing at Fourteenth and Pennsylvania Avenue I was run down by an automobile and badly injured, and a traffic policeman and a man passing helped me up, but I found I could not stand; and the woman who ran me down offered to take me to the All-States Hotel in her machine, and she did. The traffic policeman followed in an automobile, and when I got over to the hotel the traffic policeman helped me in. I found I could not stand on that leg (indicating) at all, and then he insisted that an ambulance be sent for, and they sent for an ambulance from Emergency Hospital. The intern with the ambulance thought the leg was broken, and I was taken over there and two of my friends went over with me, one in the ambulance and one called afterward. When I reached the hospital they took me to the emergency room and then I told them I was a member of Group Health, and the intern there said they did not recognize—

Mr. Leahy:—We object to what the intern said.

The Witness:—So, then, I called a Group Health physician, but I didn't have the night telephone number and it wasn't in the telephone directory at that time, because they were recently given it. So I suggested several people to telephone to, and they could not get any of them; they were not in at that time. So one of the friends who came with me agreed privately that she would telephone to a Group Health doctor in the morning. She didn't have the night telephone number. So an intern came around and I said, "Well"—

Mr. Leahy:—I object to what the intern said.

Mr. Kelleher:—Your Honor, I can connect it up with the hospital.

The Court:—I am inclined to think, gentlemen, that it would be admissible. The intern is a proper agent or officer of the hospital to act in these situations, and in view of what we have already, that would be admissible.

By Mr. Kelleher:

Q.—What did the intern say? *A.*—The intern told me that I couldn't stay there as a member of Group Health; that I could send for a physician outside if I wanted to; and I suggested one of the doctors who is a member of the emergency staff, but they said he was not a surgeon, so he wouldn't do. Then this intern told me that I couldn't stay there at all as a member of Group Health and I couldn't stay there that night unless I permitted the hospital to choose the physician. Then I asked him whom he was going to select, and he said Dr. Marbury. I didn't know him, but I agreed to anything at that time, it was taking so long telephoning.

Q.—Let me ask you a few questions about your experience in the emergency room. First, how long did the conversation between you and the intern take? *A.*—I think in the various telephone calls, and so forth, it must have taken nearly an hour.

Q.—After he told you that he did not recognize Group Health, did he leave the emergency room? *A.*—Well, you see there was a wall between where I was laid out on one of the emergency beds and the place where he telephoned. So I don't know. He was around on the other side, and he kept coming back and forth, talking to me.

Q.—Did you receive any treatment at all while you were in the emergency room? *A.*—No; none whatever. But when I agreed to take a room, then I was taken up to the room and the nurse took care of me the best she could that night.

Q.—What did she do for you? *A.*—She used hot water bottles, if I remember rightly. There was no medical attention that night. That was all.

Q.—Did any doctor come in that night? *A.*—No.

Q.—Dr. Marbury did not come? *A.*—No.

Q.—Did you want Dr. Selders to come that night? *A.*—I don't know. I wanted some one of the Group Health doctors that night, but as they could not get in touch with them I of course had to give up that, and there was nothing for me to do except to agree to stay, you see. And then the next morning Dr. Marbury came in and ordered an x-ray, and shortly after he had left Dr. Selders came in. I then told him what had happened and told him that I had no objection to staying at Emergency if he could arrange it; and it was agreed that if he could not arrange it he would send in some ambulance men and have me taken to another hospital. I think it must have been less than half an hour when the ambulance men came in for me and they put me on a stretcher and gathered up my things. No nurse came in at all, which surprised me. And then I was taken down and turned over to Garfield Hospital.

Q.—What occurred at Garfield Hospital? *A.*—At Garfield they admitted me at once and Dr. Selders came in and ordered an x-ray, and that was taken, and I was taken to a ward at first, and then was taken to a semiprivate room. Dr. Selders there came in to see me every day and he was just splendid and gave me the best of care and left his directions daily with the nurse. So that I had nothing to complain about as to the hospital treatment. It was very good.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Do you recall what day this was, Miss Abbott? *A.*—You mean, of the accident? It was the 26th of January.

Q.—1938? *A.*—Yes.

Q.—Do you recall about what time it was? *A.*—That it happened?

Q.—Yes. *A.*—It must have been about 10 or a little after.

Q.—In the morning? *A.*—Oh, no; at night.

Q.—Do you recall what time you got to Emergency Hospital? *A.*—Well, I don't know. I suppose the time it took me—it must have been about half past 11—no; it couldn't have been that late. It was before 11; half past 10, perhaps.

Q.—When was it you tried to reach the doctors of Group Health? *A.*—At the hospital?

Q.—Yes. *A.*—I don't know the time. It was just after I was taken in there. I at once told the intern that I was a member of Group Health and wanted a Group Health physician.

Q.—Do you recall how long it was that you tried to get the doctors of Group Health? *A.*—I should say it must have been an hour. My friends say it was along toward midnight before they got away.

Q.—From 10:30, when you came into the hospital, up until midnight you were still unable to get in touch with doctors on Group Health? *A.*—No; I could not reach any of them. The people they telephoned to they could not reach, so we could not get the doctors.

Q.—Did you call for any doctor that night at all at Emergency Hospital? *A.*—No. I just suggested that doctor who was on their staff, and the intern said he was not a surgeon, so he would not consider it.

Q.—Did anybody make any suggestion about getting another doctor? *A.*—Just the intern. The only suggestion he made was when he told me that I couldn't stay there unless the hospital was permitted to select the doctor. That was the only time he made any suggestion.

Q.—Was that that night? *A.*—Yes.

Q.—When you found out you could not get a Group Health doctor, then you said to the intern that you would take a doctor from their staff? *A.*—No; I didn't say that. He just said that I couldn't stay unless they selected the doctor. He made me agree to that. I agreed to take a room.

Q.—Did he say the doctor was on the staff? *A.*—He didn't say that. It was just simply the Emergency Hospital's selection.

Q.—Did you try to get any doctor that night at anybody's suggestion after you found you could not get a Group Health doctor? *A.*—No; I did not.

Q.—Did they assign you to a room? *A.*—Yes. I agreed to take the room and they suggested the room, and I asked whom they were going to get, what doctor, and then the intern said Dr. Marbury, whom I didn't know.

Q.—Had you been in Washington long? *A.*—About 29 years.

Q.—You had never heard of Dr. Marbury? *A.*—No.

Q.—Did Dr. Marbury come the next morning? *A.*—Yes.

Q.—What time did he come? *A.*—I couldn't tell you. It was early.

Q.—Would you say, before 8 o'clock? *A.*—Somewhere around that time.

Q.—When was it that Dr. Selders came? *A.*—It couldn't have been more than half an hour after—it was less than half an hour after Dr. Marbury left. Dr. Marbury didn't stay but a few minutes.

Q.—Do you know how it was that somebody got in touch with Dr. Selders that morning? *A.*—Yes. A friend of mine from the All-States Hotel telephoned as soon as she could.

Q.—Did she 'phone from the hospital? *A.*—No. You mean, the next morning?

Q.—Yes. *A.*—No. I think she must have telephoned from the All-States Hotel.

Q.—Do you recall now about what time you got to Garfield Hospital? *A.*—I don't know. I suppose it couldn't have been later than around 10:30 suppose, the next morning.

Q.—Did you have any chat with Dr. Marbury at all when he came in? *A.*—He examined my leg and asked how it happened, and that is all. Nothing was said otherwise.

Q.—Dr. Marbury was the only doctor who saw you outside of Dr. Selders? *A.*—Yes.

Q.—Did Dr. Marbury recommend that an x-ray be taken? *A.*—Yes. That is all he did. He just examined that leg and recommended an x-ray, and said nothing else.

Q.—Do you remember the name of the intern? *A.*—Why, I didn't know him.

Q.—You did not hear anybody mention his name? *A.*—No.

Q.—When you got to Garfield Hospital an x-ray was taken, was it? *A.*—Yes.

Q.—And then you were assigned to a semiprivate room? Is that what you called it? *A.*—Yes.

Q.—How long were you in Garfield Hospital? *A.*—Three weeks.

Mr. Lewin:

U. S. EXHIBIT 475

Exhibit 475 is a letter from Gist Blair, president of Emergency Hospital, to the president and board of directors of Garfield Memorial Hospital, dated Jan. 27, 1938, on the letterhead of the Central Dispensary and Emergency Hospital:

"Gentlemen:

"Miss Sarah Abbott was brought to this institution by the hospital ambulance on the evening of January 26th. She was given first aid in the Emergency Room and assigned to a bed in the hospital under the care of the staff surgeon on that service, with a diagnosis of possible fracture and possibly other injuries.

"On January 27th, about noon, Dr. Raymond E. Selders, of Group Health Association, Inc., called and requested permission from the hospital authorities to take over the medical care of Miss Abbott, due to the fact that she was a member of Group Health Association, Inc.

"Dr. Selders was advised that we were informed that he was not a member of the District Medical Society and he was not on our courtesy list, and therefore we could not extend him the privileges requested. It is a prerequisite with this hospital for practicing physicians, to become a member of our courtesy list, to belong to the Medical Society of the District of Columbia.

"Dr. Selders contacted Dr. Henry Rolf Brown, at his office, in charge of Group Health Association, Inc., whereupon Dr. Brown called the Superintendent of this hospital and demanded a direct answer as to whether Dr. Selders would be permitted to take entire direct medical charge of the patient. He was advised that, due to the fact that Dr. Selders was not on our courtesy list, we could not extend to him that privilege, but Dr. Selders was advised that he would be privileged to visit and observe the patient and consult with the staff doctor in charge. Dr. Brown then advised that he was sending an ambulance for the patient to be removed from this institution, and a short time later an ambulance from Garfield Memorial Hospital arrived, and we understand the patient was taken to Garfield Memorial Hospital.

"We shall be under obligation to you for a full explanation of the circumstances under which this patient has been permitted to enter Garfield since it is not unlikely that we may be criticized for having declined to care for the patient as described when Garfield apparently is willing to take the patient as described.

"Thanking you for as full an explanation of this case as you can possibly give us,

"Very truly yours,
"Gist Blair,
President."

And then it says:

"P. S. Copy to Medical Society, District of Columbia."

And then:

"1/28/38. Patient—Miss Sarah Abbott, admitted to Ward H, at 3 p. m.
"1/27/38. Fractured leg. Condition good, though uncomfortable. Brought in by private ambulance, and is a patient of Dr. Selders, who still has temporary privileges."

And then some initials in handwriting.

U. S. EXHIBIT 476

The next is U. S. Exhibit 476, which is the reply of the president of Garfield Memorial Hospital to that communication from Major Blair, dated Jan. 29, 1938:

"Dear Major Blair:

"Your letter of the 27th in regard to Dr. Selders' patient has been sent to me.

"This patient was brought in to the Garfield Hospital by private ambulance on the 27th at 3 p. m., with a fractured leg, and was admitted to Ward H.

"In regard to Dr. Selders himself, he had been given the temporary courtesy privileges in accordance with our general practice, pending report on his credentials and standing, by the Staff. Upon the recommendation of the Staff these temporary courtesy privileges were withdrawn from Dr. Selders by the Board of Directors at its meeting on Tuesday the 25th instant. However, the notification of this action had not been received by Dr. Selders on the 27th when the patient in question was brought to the Hospital.

"I observe that you have sent a copy of your letter under acknowledgment to the Medical Society of the District of Columbia, and I am, therefore, sending a copy of this reply to them also.

"Yours very truly,
"Clarence A. Aspinwall,
President."

U. S. EXHIBIT 76

The next is Exhibit 76, which is an original letter from President Blair of Emergency Hospital to the Medical Society of the District of Columbia, dated Jan. 27, 1938:

"Attention Dr. Coursen B. Conklin, Secretary."
"My dear Dr. Conklin:

"I feel sure that the Medical Society of the District of Columbia wish this hospital to be able to carry on its work without unnecessary criticism, and we never have any favorites in the medical profession, although we have a staff of physicians accepted as the leading physicians in the city of Washington, who generously extend the privileges of the hospital to all those whom they believe capable and proper. This list is called our courtesy list.

"Inasmuch as we cooperate with the Medical Society wherever we believe the best interests of the public are served by it and we sustain our staff in its selection of this courtesy list, provided it includes the leading practitioners of the District of Columbia, therefore the enclosed letter is one which I wish you would bring before your Board and executive authorities. I would suggest that the enclosed letter be read carefully and a reply, which will enable us to not only care for this case but similar cases which may arise in the future, be given us.

"Thanking you.

"Very truly yours,
"Emergency Hospital.
"Gist Blair,
President."

U. S. EXHIBIT 75

The next is Exhibit 75, which is Dr. Conklin's reply to Major Gist Blair, dated Jan. 29, 1938:

"Mr. Gist Blair, President,
Emergency Hospital,
Washington, D. C.
"Dear Dr. Blair:

"Your communication of Jan. 27, 1938, has been received. The important subject matter will be given prompt consideration.

"Very truly yours,
"C. B. Conklin, M.D.
Secretary.

"cc—Dr. J. Ogle Warfield Jr., Chairman,
Hospital Committee."

U. S. EXHIBIT 77

Exhibit 77 is Dr. Conklin's letter to Dr. J. Ogle Warfield, Chairman of the Hospital Committee, Washington, D. C., dated Jan. 29, 1938:

"Dear Dr. Warfield:

"I am enclosing herewith correspondence which is self explanatory, for such action as your committee may deem proper.

"Very truly yours,
"C. B. Conklin, M.D.
Secretary.

"cc—Dr. Thomas E. Neill, President."

And the enclosures are copy of a letter from Gist Blair, President of Emergency Hospital, to the President of Garfield Memorial Hospital, dated Jan. 27, 1938, which has just been read, and a copy of the response of the president of Garfield Memorial Hospital to the president of Emergency Hospital, dated Jan. 29, 1938, which has just been read.

Mr. Lewin:—I should like at this time to read certain correspondence had with the Washington Sanitarium, which is located in Takoma Park. The first is Exhibit 528, which is a letter from C. B. Conklin, M.D., Secretary of the Medical Society of the District of Columbia, dated July 29, 1937, sent to the Washington Sanitarium, at Takoma Park. It reads:

U. S. EXHIBIT 528

"Dear Doctor:

"It may have come to your attention that there is an organization or organizations that are interested in gaining medical personnel. Your attention is called to Chapter IX, Article IV, Section 5 of the Constitution, quoted in full.

"You are particularly urged to submit to the Compensation, Contract and Industrial Medicine Committee, pursuant to the Constitution, any or all contracts, written or verbal, under which you may contemplate giving your services.

"Very truly yours,
"C. B. Conklin, M.D.
Secretary

Mr. Lewin:—The next is 529, which I will not read, and which is a letter from Conklin, Secretary of the Medical Society of the District of Columbia, which it was testified went to all the members of the Medical Society and all hospitals. It is dated July 29, 1937, enclosing this so-called approved list, which omits the name of Group Health.

Exhibit 451 is Mr. Kirkpatrick's letter to Mr. Rice, Credit Manager, Washington Sanitarium and Hospital, dated Feb. 4, 1938, reading as follows:

U. S. EXHIBIT 451

"Dear Mr. Rice:

"There is enclosed herewith an application executed by Dr. Raymond E. Selders, a surgeon on the staff of Group Health Association, Inc., for appointment to the staff of Washington Sanitarium and Hospital.

"It will be very much appreciated if this application may be presented to the proper body and advise us of such action as may be taken. Your prompt attention to this matter will be appreciated."

Mr. Lewin:—The next is Exhibit 452, a letter from Robert A. Hare, M.D., from Washington Sanitarium, to Mr. W. C. Kirkpatrick, President, Group Health Association, dated Feb. 8, 1938:

U. S. EXHIBIT 452

"My dear Mr. Kirkpatrick:

"Your letter of February 4 accompanied by an application from Dr. Raymond E. Selders, for appointment on the staff of the Washington Sanitarium and Hospital, has been received.

"This application will have consideration at an early date and we will notify you of the action taken promptly."

Mr. Lewin:—The next is a letter from Dr. Hare, Washington Sanitarium, to Mr. W. C. Kirkpatrick, Group Health Association, dated Feb. 14, 1938. It is Exhibit 453:

U. S. EXHIBIT 453

"My dear Mr. Kirkpatrick:

"In harmony with my recent communication I will state that our Board has considered the application of Dr. Raymond E. Selders which has come to us through your hands.

"In view of the fact that there are some problems existing between health groups and physicians, it was voted that the application be tabled, without prejudice, until your organization is recognized or approved by the American Medical Association or its local units. When a suitable plan is worked out in this line of endeavor we will be glad to consider this subject with you again. In the meantime, I am

"Very truly yours,
"Robert A. Hare, M.D."

Mr. Lewin:—The next is 455, a copy of a letter from Mr. Kirkpatrick to Robert A. Hare, Medical Director, Washington Sanitarium, dated July 29, 1938:

U. S. EXHIBIT 455

"My dear Dr. Hare:

"In view of Justice Bailey's decision yesterday establishing the legality of Group Health Association, Inc., it is respectfully requested that Dr. Raymond E. Selders, a member of our staff, be admitted to the courtesy staff of Washington Sanitarium and Hospital, and that he may attend members of this Association admitted as patients there.

"We shall appreciate the courtesy of an early reply.

"Very truly yours,
"W. C. Kirkpatrick,
President."

Mr. Lewin:—Exhibit 456 is a letter from Dr. Hare to Mr. Kirkpatrick, dated Aug. 8, 1938:

U. S. EXHIBIT 456

"My dear Mr. Kirkpatrick:

"Your letter of July 28 has been received. Would state that the question you raise will have consideration in due course.

"Sincerely
"Robert A. Hare, M.D.
Medical Director."

Mr. Lewin:—The next and last is 457, which is Mr. Kirkpatrick's letter to Dr. Hare, dated Sept. 16, 1938:

U. S. EXHIBIT 457

"Dear Dr. Hare:

"On Aug. 8, 1938, you advised me that the application of Dr. Raymond E. Selders for admission to the Courtesy Staff of your hospital, which was the subject matter of my letter of July 28, 1938, would have consideration in due course.

"I shall appreciate it very much if I may have some advice from you as to what action that may have been taken in the meantime.

"Very truly yours,
"W. C. Kirkpatrick,
President."

MARCH 3—MORNING

Mr. Lewin:—May it please the Court, I think, in order to make the record clear, I should restate the Government's offer in evidence of those portions of the minutes of the District Medical Society and its executive committee and the documents referred to in and attached to the minutes. I refer, of course, only to those minutes which were identified as such by the defendant Wiprud, and I refer to all of them except the minutes of the Society for Jan. 6, 1937 and March 3, 1937, no portions of which were offered as yet.

The Government's offer includes, and only includes, those portions of the minutes which show the attendance, the fact of participation of all persons present at the meeting, and those portions which show the approval of the minutes of any prior meetings, and all of the portions of the minutes which were read to the jury by Government counsel, whether marked as hereinafter indicated or not, and all portions of those minutes or other papers attached thereto which have been marked with colored crayon in photostatic copies of the minutes; the said photostatic copies of these minutes as bearing these markings being likewise offered merely for the purpose of identifying these portions. All of this evidence was offered and received, as I understand it, against all of the defendants as against whom the Court has determined or may determine that a prima facie case as charged in the indictment has been established, either by this evidence or by any other evidence offered or to be offered by the Government in this case.

THE COURT:—If you will pass me a copy of that I will reread it.

(Mr. Lewin handed a memorandum to the Court.)

TESTIMONY OF DR. WALTER ARTHUR COOLE

DIRECT EXAMINATION

By Mr. Allen:

Walter Arthur Coole said that during the period from Oct. 30, 1937, to Nov. 23, 1938, he was secretary of the Harris County Medical Society. He was authorized by the Society to appear on behalf of that society in this court.

Q.—I wish to show you Government Exhibit 73-A, which is now in evidence, and ask you if you, as an official of the Harris County Medical Society, received a copy of that from Dr. Taylor? *A.*—I did not receive the copy. The President received the copy.

Q.—And it came to the Society's attention? *A.*—Yes, sir.

Q.—I next show you Exhibit 537, which is a letter from Dr. Holman Taylor dated Nov. 24, 1937, to Dr. B. F. Smith of the Harris County Medical Society, and ask you if that came to the Society's attention? *A.*—Not to my knowledge; no, sir.

Q.—Is that Dr. Taylor's signature (indicating)? *A.*—Yes, sir.

Q.—And you are acquainted with Dr. B. F. Smith? *A.*—Yes.

Q.—I next show you Government Exhibit 538, which is a letter dated Nov. 25, 1937 from Dr. P. M. Ashburn to the Secretary of the Houston Medical Society, and ask you if you received that letter as the Secretary of the Harris County Medical Society? *A.*—Yes, sir.

(The witness identified signatures, correspondence and minutes concerning Holman Taylor, A. B. Talley, C. B. Conklin, The Judicial Council, Minutes, Olin West, etc., relative to membership of Raymond E. Selders in the Harris County Medical Society.)

Your Honor, I do not wish to offer any of these documents at this time; and I am through with the witness.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Is the Harris County Medical Society a component society of the American Medical Association? *A.*—A component society?

Q.—Yes. *A.*—I don't know what that means, sir.

Q.—Do you have any State Society in Texas? *A.*—Yes, sir.

Q.—What is that called? *A.*—The Texas State Society.

Q.—What is the Harris County Medical Society? *A.*—The Harris County Medical Society is an association of doctors who practice in Harris County.

Q.—When was it formed, if you know. *A.*—You mean, the origin of the Society?

Q.—Yes. *A.*—The origin of the Society began with the 14 doctors who fought in the Battle of Sandy Center and settled in Harris County; and the Society itself was formerly called the Houston Medical Society in 1892, and it was extended to include all of Harris County in 1903.

Q.—What was this battle you spoke about?

Mr. Lewin:—I object to this going any further. I think it is legitimate enough to get in the Medical Society, but when counsel wants to go into a battle I think that is going a little beyond the proper scope.

Mr. Leahy:—Don't you like battles?

Mr. Lewin:—We have plenty of battles on our hands right here.

By Mr. Leahy:

Q.—Under the rules of the Society were you authorized to keep minutes? *A.*—Yes, sir.

Q.—Are you a shorthand reporter yourself? *A.*—I write shorthand; yes, sir.

Q.—Did you take down in shorthand just what was said, or did you take what you thought was the substance of what was said? *A.*—I took down what I could to the best of my ability.

Q.—Word for word as each one spoke? *A.*—Some of it was word for word, and some was in notes.

Q.—Then, after you had taken it down in shorthand, about a week later, you say, you wrote up the notes? *A.*—Usually within a week; as soon as I could get to them.

TESTIMONY OF DR. GEORGE B. TRIBLE

DIRECT EXAMINATION

By Mr. Lewin:

(George B. Trible said he is a practicing physician of the city of Washington. His specialty is otolaryngology—ear, nose and throat.)

Q.—Did you have occasion to operate upon a young boy named Lewey Gilstrap in November of 1937? *A.*—Yes, sir.

Q.—Will you tell the jury the circumstances under which you agreed to perform that operation? *A.*—I was called to see

this case, and I found that they were members of Group Health Association, but there was no specialist in their group, and they had been referred to me. I did an immediate operation, which was opening of the eardrum, and I explained to the father that I would not be able to handle the—

Mr. Leahy:—I object to any conversation.

THE COURT:—Objection sustained.

The Witness:—The case was taken to the Children's Hospital. It was first x-rayed by Dr. Bierman, roentgenologist or x-ray man in this city, which confirmed the diagnosis of an acute mastoiditis. The case was taken to Children's Hospital and admitted, and I operated, I think, that same night, or the next morning—it was the next morning.

Q.—Who was present during the operation? *A.*—The hospital anesthetist.

Q.—What was his name? *A.*—Dr. Macon. The surgical assistant was named Dr. Cohen, and the nurses who were in attendance.

Q.—Anybody else? *A.*—During the course of the operation Dr. Scandiffio came in, just at the time I was going through the outer layer of the bone which we call the cortex, and just as I cut through the cortex the pus came squirting up through, and he just happened to look in at that time, and stayed about five minutes and left.

Q.—How did he happen to come there? *A.*—The night before he called me up and said—

Mr. Leahy:—I object to the conversation.

THE COURT:—Objection sustained.

By Mr. Lewin:

Q.—He called you up. Did you invite him to come? *A.*—He asked permission to come.

Q.—Did he come as a result of that conversation? *A.*—Yes, sir.

Q.—Was this patient taken there by you and operated on as a private case? *A.*—Yes, sir.

Q.—How serious an operation was it, Doctor? *A.*—Acute mastoiditis, with an abscess around the big vessel that goes beneath the mastoid bone.

Q.—Was the abscess large? *A.*—Yes, sir.

Q.—Did the patient make recovery all right? *A.*—A perfect recovery.

Q.—To whom did you send your bill? *A.*—To the patient's father.

Q.—Mr. Gilstrap? *A.*—Yes, sir.

Q.—Who paid it? *A.*—The check was received from the G. H. A.

Q.—Do you know who had charge of your Lewey Gilstrap and was looking after him, before you saw him? *A.*—I think, Dr. Scandiffio saw him before I saw him. I am not clear on that.

Q.—Had you known Dr. Henry Brown, the medical director of Group Health Association? *A.*—Many years.

Q.—Had he been a personal friend of yours? *A.*—For many years.

Q.—You knew he was Medical Director at that time? *A.*—Yes, sir.

Q.—Did you make any report to Dr. Brown upon your handling of the Gilstrap case? *A.*—Yes, sir.

Q.—I show you Government Exhibit 567 and ask you whether that is a copy of the report which you gave to Dr. Brown? *A.*—A carbon copy of the report, sir.

Q.—Is is dated Dec. 20, 1937? *A.*—Yes, sir.

Mr. Lewin:—I offer it in evidence (handing paper to Mr. Leahy).

Mr. Leahy:—I will pass that up to your Honor. It strikes me that it is entirely immaterial. It is a copy of a report which was rendered to Dr. Brown (handing letter to the Court).

THE COURT:—What is the materiality of it?

Mr. Lewin:—It will come out clearly as the examination proceeds.

THE COURT:—I doubt its admissibility. Objection sustained.

By Mr. Lewin:

Q.—At that time were you a member of the District Medical Society and of the A. M. A.? *A.*—Yes, sir.

Q.—Have you continuously been a member since that time? *A.*—Before and since; yes.

Q.—Did you know the defendant R. Arthur Hooe? *A.*—Yes, sir.

Q.—Did you know that he was chairman of the Compensation, Contract and Industrial Medicine Committee of the District Medical Society? *A.*—Yes, sir.

Q.—Did you receive in May of 1938, six months after this operation, a letter from Dr. R. Arthur Hooe? *A.*—I did.

Q.—I show you Government Exhibit 568 and ask you if that is the letter you received from the defendant Hooe? *A.*—That is the letter.

Mr. Lewin:—I offer it in evidence (handing letter to Mr. Leahy).

Mr. Leahy:—O. K.

Mr. Lewin:—No objection?

Mr. Leahy:—No.

(Letter dated May 14, 1938, from Hooe to Trible was marked U. S. Exhibit 568 and received in evidence.)

U. S. EXHIBIT 568

Mr. Lewin:

"May 14, 1938."

It is on the letterhead of the Medical Society of the District of Columbia:

"Dr. George B. Trible
1801 I Street N.W.,
Washington, D.C.
"Dear Dr. Trible:

"You are hereby directed to appear before the Compensation, Contract and Industrial Medicine Committee at the Medical Society Building, 1718 M Street, N.W., on Tuesday evening, May 17, 1938, at 8 p. m.

"Very truly yours,
"R. Arthur Hooe, M.D.,
"Chairman of the C. C. & I. M. Committee."

By Mr. Lewin:

Q.—Had you ever received a communication like that before from that committee? *A.*—No, sir.

Q.—What, if anything, did you do to prepare yourself for that committee meeting? *A.*—As I recall it, I secured a statement from the parents of the patient regarding the case, and from Dr. Brown regarding the case.

Q.—At that time was Dr. Brown still Medical Director of the Group Health Association? *A.*—Yes, sir.

Q.—Are you sure of that, Doctor? Had he not resigned at that time? *A.*—My impression is that he was still a member.

Q.—Did you determine to obey this summons to attend this meeting as directed? *A.*—Earlier than directed. I had something I had to do later, and I asked permission to come in at 7:30.

Q.—I show you Government Exhibit 569 which purports to be a statement of Mr. Lewey O. Gilstrap, dated the 16th of May, 1937, and I show you also Government Exhibit 570 which appears to be a statement of Dr. Brown, dated May 15, 1937, and ask you whether they are statements which you obtained in preparation for this hearing. *A.*—True statements, and notarized.

Mr. Lewin:—I offer them in evidence.

By Mr. Lewin:

Q.—Let me ask you this. Did you take these statements with you to the committee hearing? *A.*—As I recall; yes, sir.

Q.—And submitted them to the committee? *A.*—Yes, sir; and the letter.

Q.—The letter which you sent to Dr. Brown, Exhibit 567? *A.*—Yes, sir.

Q.—Were those documents considered by the committee in your presence? *A.*—The committee meeting was very short—

THE COURT:—You mean, were they read?

Mr. Lewin:—Yes, or considered.

By Mr. Lewin:

Q.—Were any questions asked about the contents of them? *A.*—The meeting was very informal. It lasted a very short time. I did not pay much attention to it; I thought nothing of it.

Q.—Who was present? *A.*—As I recall, Dr. Hooe, Chairman; Dr. Fred Sanderson, member—

Q.—Is that Dr. Fred R. Sanderson? *A.*—Yes; Dr. Putzki, a member.

Q.—That is Dr. Paul S. Putzki? *A.*—Yes, sir; and Dr. Greear, a member.

Q.—And Dr. Nicholson? *A.*—Yes, sir; a lady doctor.

Q.—Who asked you questions at the committee hearing? *A.*—There were very few questions asked. Dr. Hooe asked a few. It was very informal.

Q.—What was the subject matter of the questions? *A.*—My relationship with Dr. Brown and with this case, and relationship with G. H. A. in general.

Q.—Were you asked questions about the Gilstrap case and your handling of it? *A.*—Yes.

Q.—And your personal relationship with Dr. Brown? *A.*—Yes, sir.

Q.—Had you had luncheon with Dr. Brown at times? *A.*—Frequently, before and since.

Q.—Was that the subject matter of the questions? A.—My mind is very vague. I think it was whether I knew him well, and so forth.

Q.—And this report which you made to him on the Gilstrap case was also discussed? *A.*—Yes.

Q.—And you were asked questions about that? *A.*—Yes, sir.

Mr. Lewin:—I re-offer, in view of the testimony, Government Exhibit 567, and I also offer at the same time Government Exhibits 569 and 570.

Mr. Leahy:—The same objection, if your Honor please. I cannot see how they are material. It has already been covered in the testimony (handing papers to the Court).

By Mr. Lewin:

Q.—Did you leave these three documents with the committee? *A.*—Yes, sir.

THE COURT:—They will be admitted.

Mr. Lewin:—The first is Government Exhibit 567, which is a copy of Dr. Trible's report to Dr. Brown, dated Dec. 20, 1937. He testified he made it after the operation on Lewey Gilstrap.

Mr. Lewin:

U. S. EXHIBIT 567

"Dec. 20, 1937.

"Dr. Henry R. Brown, Group Health Assn.,
1328 Eye St., N. W., City.

"Dear Dr. Brown:

"Complying with your request for information regarding Lewey Gilstrap, whose father is a subscriber to the G. H. A., and as such is entitled to treatment for his family by the Association, but who was seen by me on several occasions and operated on at Children's Hospital as a private patient. He was seen at home on November twenty-second, twenty-third, and twenty-fourth, a paracentesis being performed on November twenty-third at the home. This case presented a great many difficulties of diagnosis. The child was very patently sick. He had given a history of previous trouble, which had necessitated several days hospitalization last year. He suffers from enlarged tonsils and adenoids, both evidently infected. He was directed to be brought to this office on November twenty-fourth, which time an X-ray was taken by Dr. H. I. Bierman, a copy of which report is enclosed. He was operated at Children's Hospital on November twenty-fifth, disclosing a large mastoid abscess which had perforated the outer cortex of the mastoid and which corresponded to the painful spot which had been a marked symptom throughout. Cultures from the pus, made in the Children's Hospital laboratory showed strep hemolyticus. The child made a very good recovery, was discharged from the hospital in about a week, and comes into this office every other day for treatment.

"Sincerely,
"G. B. Trible."

Government Exhibit 569 is the statement which Dr. Trible obtained from the father of Gilstrap, dated May 16, 1938, in the form of an affidavit.

U. S. EXHIBIT 569

Mr. Lewin:

"District of Columbia, } Affidavit.
City of Washington, }

"Lewey O. Gilstrap, of lawful age, being first duly sworn on oath deposes and says: That to the best of his knowledge he is now a member, in good standing, of Group Health, Inc., Washington, D. C., and that he was such member at all times hereinafter mentioned.

"That on the 24th day of November, 1937, it was discovered by doctors in the said Group Health that Lewey G. Gilstrap Jr., son of affiant, was suffering from Mastoiditis; that said Group Health, at that time, had no doctor on its staff who specialized in such cases, and it had no facilities to care for such cases, and affiant was advised by said doctors that it would be necessary to obtain a competent physician in private practice in Washington to attend to the case.

"That affiant, having confidence in the ability of Dr. G. B. Trible in such cases, took his son to the office of said Dr. Trible on the evening of Nov. 24, 1937, and asked for his advice in the case. That Dr. Trible examined the boy and advised the placing of the boy in the Hospital at once, and on the next morning, and on Nov. 25, 1937, Dr. Trible performed a mastoid operation on the boy, which operation was entirely satisfactory.

"That from the time affiant took said boy to the office of Dr. Trible, the said doctor considered him a private patient, and was looking to affiant for payment of his fees, and affiant agreed to be responsible for said fees.

"Witness my hand this 16th day of May, 1938.
"Lewey O. Gilstrap.

"Subscribed and sworn to before me this 16th day of May, 1938.
"Anthony De Poto
"Notary Public."

Q.—Shortly after that meeting with the committee, were the papers that you left with the committee returned to you? *A.*—Shortly after, returned by Dr. Hooe in person.

Q.—Where were they returned to you? *A.*—To my office, then at 1801 I Street.

Q.—Do you remember how long after it was they were returned to you? *A.*—I don't recall.

Q.—Wasn't it shortly after? *A.*—Yes.

Q.—Will you tell the jury what transpired when Dr. Hooe came to your office? *A.*—Well, he brought back the papers—

Q.—First, do you remember exactly what was said there in every detail? *A.*—Yes, in every detail. It made quite an impression on me. So I said, "That is fine"; I looked them over. He said, "Well, I am resigning from the chairmanship of that committee." He stated, "You will have to appear before the executive committee." I was a little surprised at that. I hadn't paid any attention to it. I thought it was just a matter of form, of no consequence; I didn't take it seriously. So he said, "You have done wrong" and he said, "If I could see things as he did, and when the time came, to come to him, then I could go to sleep soundly." I didn't have any trouble about sleeping; I didn't think I had done anything to be worried about. We had a long harangue there in my office. I don't recall it in detail. He asked me about Dr. Brown and I told him that I had known Dr. Brown for a great many years; that "He is a very fine fellow." He said, "Yes, so was Dillinger; he was a fine fellow too." It continued to get a little more exciting there. He got up and he said, "Well, you will have to be careful of this society." He said, "The Medical Society"—I don't know, should I repeat what he said?

Mr. Lewin:—Well, characterize it: was it some vulgarity?

The Witness:—Yes, it was some vulgarity; "That the members of the society were S. O. B.'s. That they are not fit to lace your shoes, but they will pass judgment on you." I didn't feel that way about it. I hadn't done any wrong.

Q.—What physical appearance did he manifest on that occasion, while he was talking to you? *A.*—He was walking around, back and forth; excited; I thought he was going to have a stroke.

Q.—What was the pitch of his voice? *A.*—It raised to a crescendo.

Q.—All right, he left these papers with you and said you would be passed on by the Medical Society, executive committee?

THE COURT:—Don't repeat it.

Mr. Lewin:—I was just trying to get that clear.

THE COURT:—You are merely summarizing.

By Mr. Lewin:

Q.—Did you do anything more to prepare for that meeting? *A.*—It so impressed me that immediately upon his leaving I took a prescription pad and jotted down notes of what transpired.

Q.—And you have those notes? *A.*—Yes.

Q.—And have looked at them from time to time since? *A.*—Yes.

Q.—Did you receive any further communication from the Medical Society on the subject? *A.*—I received a communication, I don't recall, he brought this report and then I got a communication from the executive side.

Q.—He brought this report, did he? *A.*—Yes.

Q.—What did the report say? *A.*—That I had been found guilty of violating Article so and so, relating to contract practice.

Q.—Were there any other circumstances than the ones concerning which you have testified now upon which such finding of guilty could have been based? *A.*—Not to my knowledge; I have followed the rules.

Q.—I show you Government's Exhibit 571, and ask you whether that is the report the defendant Hooe brought you on that occasion? *A.*—Yes.

Mr. Lewin:—I offer it in evidence.

Mr. Leahy:—It is not a report.

Mr. Lewin:—You can characterize it as anything you want.

Mr. Leahy:—You said it was a report.

Mr. Lewin:—I didn't do any such thing; the witness said it was a report, and I offered it in evidence.

THE COURT:—Whatever it may be called, it will be admitted. There may be some question as to what it will be called.

Mr. Lewin:—It will speak for itself.

THE COURT:—Yes, it will.

Mr. Lewin:—Exhibit 571 is dated May 17, 1938, and is addressed to Dr. George B. Trible. It reads:

U. S. EXHIBIT 571

"The Committee hereby charges you with having violated Section 2 of Article 3 of Chapter 9 of the Constitution of the Medical Society of the District of Columbia, reading as follows:

"'Every member of the Society before entering into a contract or agreement for rendering professional service shall submit a copy of his contract, if written, or a true declaration of the terms of the agreement, in writing, to the Committee on Compensation, Contract and Industrial Medicine for approval. In the event that the committee disapproves the contract, a member may appeal to the Executive Committee.'

"And again Chapter 9, Article 4, Section 5, as follows:

" 'No member of the Society shall engage in any professional capacity whatsoever with any organization, group or individual, by whatever name called or however organized, engaged in the practice of medicine within the District of Columbia or within 10 miles thereof, which has not been approved by the Society.

" 'The Executive Committee is authorized and directed to prepare an approved list of organizations, groups and individuals, by whatever name called and however organized, engaged in the practice of medicine within the District of Columbia or within 10 miles thereof, and the same shall be kept in the office of the Secretary-Treasurer. Before any such organization, group or individual can be placed on the approved list of the Society, such organization, group or individual, or the member of the Society proposing professional relations therewith, shall submit to the Compensation, Contract and Industrial Medicine Committee such evidence as the Committee or the Society may require showing the character, activities, financial condition and ethical standards of said organization, group or individual, and after considering the same, said committee shall make a report of its investigation and findings to the Executive Committee for such action as it may deem necessary.'

"R. Arthur Hooe, M.D.
"Chairman, Compensation, Contract and Industrial Medicine Committee."

By Mr. Lewin:

Q.—Now, with reference to this matter, did you receive any further word from the executive committee? *A.*—Yes.

Q.—Specifically, did you receive Exhibit 572, which purports to be a letter to you from the defendant C. B. Conklin, dated May 31, 1938, on the letterhead of the Medical Society? *A.*—Yes.

Mr. Lewin:—I offer it in evidence.

(Letter, May 31, 1938, Conklin to Trible, marked U. S. 572, was received in evidence.)

By Mr. Lewin:

Q.—Did you do anything in preparation for that meeting? *A.*—Yes, I was very much upset, naturally, under the circumstances. I hadn't paid much attention to it before, so I got a statement from Dr. Bierman.

Q.—That was the anesthetist, or the x-ray man? *A.*—And a statement from the anesthetist, Dr. Cohen; a statement from the nurse who had posted the operation, and who was present at the operation.

Q.—Did you obtain those statements for use before the executive committee? *A.*—Yes.

Q.—In answer to those charges? *A.*—Yes.

Mr. Lewin:—This is Exhibit 572. It is the letter from Dr. Conklin to Dr. Trible, dated May 31, 1938:

U. S. EXHIBIT 572

"Dear Doctor Trible:

"You are hereby directed to appear before a meeting of the Executive Committee, on Monday evening, June 6, 1938, in the Medical Society Building, at 8 p. m.

"Very truly yours,
"C. B. Conklin, M.D.,
"Secretary."

By Mr. Lewin:

Q.—I show you Exhibits 573, 574, 575 and 576, and ask you if they are the four statements you obtained and concerning which you have just testified? *A.*—They are.

Q.—And were they sent to the executive committee by you? *A.*—Yes.

Q.—And were they accompanied by a letter from you to the executive committee dealing with these charges? *A.*—Yes.

Q.—Is Exhibit 52, which I have just shown you, the letter which you prepared and sent to the executive committee? *A.*—Correct.

Mr. Lewin:—I offer in evidence Exhibit 52—you gentlemen, I think, are familiar with it, are you not? And also these supporting Exhibits 573, 574, 575 and 576.

Q.—Did you ask any member of the executive committee to transmit these communications to the executive committee? *A.*—Yes.

Q.—Did you attend yourself? *A.*—I did not.

Q.—Did you receive any further communication from the executive committee after the date of that hearing? *A.*—Yes.

Q.—From whom? *A.*—From Dr. Sprigg; he was then chairman of the executive committee.

Q.—Can you remember what he said? *A.*—I don't recall what he said, but I recall my reply. He had said, in substance, "Don't do it again."

Q.—And you made a reply? *A.*—Yes

Q.—Do you recall your reply? *A.*—Very distinctly.

Q.—What was said by you? *A.*—I said, "Your letter received and contents noted. May I quote the motto of the Knights of the Garter of old, 'Honi soit qui mal y pense'."

Q.—And will you translate that motto? *A.*—"Evil be to him who evil thinks."

Mr. Leahy:—Will your Honor kindly look these over (handing documents to the Clerk)?

Mr. Lewin:—Do you object to them?

Mr. Leahy:—Yes, the same objection, not material.

THE COURT:—Are these submitted in connection with his answer?

Mr. Lewin:—That is his testimony.

THE COURT:—They will be admitted.

Mr. Lewin:—I will read first Exhibit 573, Dr. Bierman's statement, dated May 21, 1938. It is addressed to Dr. Trible.

"Dear Dr. Trible:

"Replying to your note regarding the Gilstrap case and the request that you appear before the Committee, I want to say that I went to see Dr. Hooe about this matter. I went to see him because I could not understand how anything could have been considered unethical in regard to our conduct in this case.

"I told Dr. Hooe that I had heard you were being questioned about the Gilstrap case and that if you were guilty I was also. I explained to him that you had told me in advance of my x-raying the patient that tho the patient had originally been treated at the Group Health he was now a private case and that he would be handled as such, and that I was to send my bill directly to the patient as in all private cases.

"Dr. Hooe reacted rather violently to my insistence that I could also be guilty, saying that the patient was referred to me by a private physician. He would not listen to my statement that I knew in advance that the patient had originally been treated at the Group Health and had been sent to you. His apparent inconsistency and vehement denial of any possibility of my also being guilty seems rather strange to me. I do not understand what is back of the whole matter, but I cannot see where one person could be guilty and another not guilty in exactly the same case when each one acted according to the accepted rules of the Society. It was impossible for me to argue with Dr. Hooe because of his very emphatic stand in the matter.

"Is it possible that there may be a personal matter back of the whole affair? The next day after I spoke to Dr. Hooe I met him on the stairs in this building coming from the third floor. I asked him whether he had been to see you in regard to the case and he said he had NOT. Later, when I spoke to you, I learned that he HAD been in to see you. I can't understand why he denied having just seen you or why he should make personal visits to a defendant outside of any regularly scheduled hearing and apparently without the knowledge of the remainder of his committee. If I can be of any assistance before the Committee, please feel free to call upon me.

"With best wishes, I remain,
"Sincerely,
"M. I. Bierman."

Mr. Lewin:—The next is Exhibit 574. It is from Dr. Edward B. Macon, to Dr. Trible, and is dated May 23, 1938.

U. S. EXHIBIT 574

"Dear Dr. Trible:

"In reply to your request for my knowledge of the Gilstrap case let me say first that I am, as you know, opposed to any dealings with Group Health Association or any similar association. I approve of the present policy of the Medical Society in their endeavor to control its member for the good of the Medical Profession and the public.

"As far as this particular case is concerned, the simple facts are that before this operation for mastoiditis you frankly stated that it had been a G. H. A. case and was now your private case. I did not then and I do not now see any reason why you could not under these circumstances treat the case.

"The investigation itself was conducted in a manner to arouse one's antagonism. On Friday May 13, 1938 I received a telephone message to call a certain number but the individual would not leave his name. To this call I paid no attention. Later he called again and left his name stating that 'I can save the Doctor some trouble if he gets in touch with him.' On getting in touch with Dr. Hooe he stated that he wanted to see me. When I asked him the nature of the business he stated that he could not discuss it over the telephone. I told him I would try and see him but that I was busy at the moment. He then said that 'he would leave it like this, that if I did not see him before noon Monday I would have to appear before a committee Tuesday evening.' As I had no reason not to appear before the committee and as this sounded like a threat I did appear before the committee. Up to that time I did not know the reason I was to appear before them. As Chairman of the Committee Dr. Hooe then told me that in view of your testimony he had no questions to ask me. Another member of the committee then asked me if I had ever received a check from the G. H. A.

"I hope this letter may clarify your association with this case and the frank way in which you dealt with it and all other matters in which it has been my pleasure to be connected.

"Sincerely yours,
"Edward B. Macon."

Mr. Lewin:—Then comes Mary O'Sullivan's statement. She was the nurse attending at the operation. Her letter is dated June 4, 1938.

U. S. EXHIBIT 575

"Dear Dr. Trible:

"In so far as I know the Gilstrap child came to us as your semi-private case, and was handled the same as your other cases.

"Sincerely yours,
"Mary O'Sullivan."

Mr. Lewin:—576 is the letter of Dr. Cohen, dated June 4, 1938, addressed to Dr. Trible:

U. S. EXHIBIT 576

"My dear Dr. Trible:

"I recall assisting you do a mastoid operation on or about Nov. 25, 1937 at Children's Hospital. I cannot recall the name of the patient, though I understand now that his name was 'Gilstrap.' During the operation I heard you say in effect that the patient was originally a member of the Group Health Association and that you had seen him through Dr. Scandiffio. You stated that at first you had not wanted to take this case, but that you had finally agreed to accept him as a private patient of your own because the nature of the illness was so acute as to require immediate operation.

"Dr. Scandiffio was present for a short while after the operation had gotten under way.

"Truly yours,
"A. Cohen, M.D."

Mr. Lewin:—Exhibit 52 is Dr. Trible's letter to the Secretary of the District of Columbia Medical Society, dated June 6, 1938. It is addressed to:

U. S. EXHIBIT 52

"My dear Doctor Conklin:

"It is a source of regret that I am unable to appear personally Monday night, but inasmuch as there has been, to my mind, no offense, no defense is contemplated. The facts relative to the G. H. A. are as follows:

"The former Medical Director, Doctor Brown, and I have been friends for years. I have treated him and his family and naturally, when he accepted the position as head of that organization, he asked me if I would consider a consultantship. I replied that if, and only if it were acceptable to the laws of the District and the by-laws of the Medical Society, I would be felt it was and wanted to cooperate and act under such laws, but seeing how I felt, he let the matter drop. I have not even seen his clinic.

"The Torch Club here asked me to present the organized medicine side of a debate. I told Mr. Elwood Street that I would be glad to help, but I was no speaker and suggested Dr. Christie, Dr. McGovern and Dr. Bennett. Then they thought it would be a good idea to have G. H. A. represented, so I asked Doctor Brown. He did not get in for dinner and for only a part of the debate and declined to speak. Dr. Christie and Dr. Bennett spoke and made a good impression on a hostile audience. I was warned after that, by two of my associates, that I was under suspicion and would be in trouble being seen with Doctor Brown. Inasmuch as he is a doctor, a gentleman and a friend, I have felt it a matter of personal privilege and not a regulatory affair.

"With a number of constituents ranging from 1,500 paying members up to 2,500, and their dependents, all multiplied by three, there naturally arose many cases in all fields. Knowing my attitude in this matter, they purposely were not referred to me. During all this time, to the best of my knowledge, two surgical cases came to me, one the case in question and the other an antrum case operated at Garfield also as a private patient, but who stated she was eligible for clinic and treatment and thought they should settle her bill. A dentist named Cling was also in this case. She found she was not eligible for treatment and personally paid her bill, as I told her I expected. She make two payments, one of $100 and one of $75. At the time she was operated, I told the anesthetist her claim, but that I had no connection with nor accepted any responsibility from that organization and looked to her personally for payment. She was also x-rayed by Dr. Bierman and treated just as any other case. She has left her job and cannot be contacted. Several patients coming my clientele at different times told me they were eligible for treatment, but I sent them all bills which they paid.

"Reverting to the Gilstrap case, there was no connection with the G. H. A. and the patient was handled as any other, arrangement made from the office for it, as is always done. I mailed the bills to the patient regularly, not discounted, but based on the Mayo plan, the same as all other major operations. Later, after several months, it was paid from the G. H. A. There was no rule at that time that such checks should not be accepted. They were so accepted by many members of the society, though I have been told by two, who had similar cases, that they called the committee before accepting them. Referring to the by-law regarding an individual not on the accepted list, I note that both you, Mr. Secretary and I, treated Dr. Penhallow's children and I understand this rule was put in to prevent his contact with members of the District Society. It is remarkable that I have never got any pay cases from him or his clinic. Evidently they are treated by other specialists.

"Then I was called before the committee. I had only a half hour. I simply told them, as I said, that I felt I needed no defense, nor do I feel so now, and went away.

"Referring to the case at Children's Hospital, Dr. Scandiffio called me regarding this case and requested permission to be present at the operation and was present for a short time about the middle of the surgical procedure. He was at that time a member of the District of Columbia Medical Society.

"With reference to the claim by the chairman of the Committee on Contracts, etc., who stated that the letter in response to a request from Doctor Brown constituted a validity to the charge, I was cooperating with them, I think the rule was that phone calls or letters reporting on such cases were permissible to other than members of the Society, but personal consultations were not. I considered this request the same as from an insurance company and so replied. I replied by letter rather than by phone so that a record could be kept. It stated clearly that this was a private case.

"The chairman of the contracts committee brought back the papers I had submitted, made a long harangue in my office, about which I immediately jotted down notes, and ended by saying if I could see things as he did, and when the time came, to come to him, then I could go to sleep soundly. I was also told that the Society was full of s. o. b's. and a . . . a . . s, but they would sit in judgment on me, though they were not worthy to lace my shoes. I told him I did not feel that way about them and a difference of opinion was understandable.

"Now there is no defense for there is no offense that I can see. I am submitting herewith certain papers to be presented for the committee. If there be any offense I am sorry and accept full responsibility, for in the case of the x-ray man and the anesthetists, I told them the circumstances and felt these were private patients, and they felt as I.

"I have deep regard for the Society and live up to its rules. I resigned as a Commander in the Medical Corps of the Navy and threw my lot with you. I know state controlled medicine as but few do, and I realize its good points and its bad ones. The men in the military services are high class men and I have always stood up for them, so much so I am called 'The Admiral' in some ridicule. It is a bad bird that soils its own nest. I stand for the District now as I stood for them and I regret if in any way I have been at fault. I do resent and have resented any infringement on personal social contacts and so do you. If there are any points I can elucidate further I will be glad so to do, but no defense is being submitted, for the facts are as I state them and I will be glad to have this passed upon by the Judicial Council of the A. M. A.

"In passing, you will note that the famous Gilstrap case was treated in semi-private accommodations and kept in the hospital a minimum of time following the mastoidectomy. This should point conclusively to the truth, which is that he wished the expenses cut down to the minimum as he fully expected to bear them himself.

"Very sincerely,
"G. B. Trible."

Mr. Lewin:—I should like to read now from the minutes of the meeting of the executive committee of the District of Columbia Medical Society held June 6, 1938. First is the letter from Dr. Hooe to the chairman of the executive committee of the District Medical Society, who was Dr. Sprigg, dated May 18, 1938. It reads:

"Dear Doctor Sprigg:

"A letter addressed to Dr. George B. Trible, under date of May 14, 1938, and sent by registered mail, follows:

And then he quotes the first letter, which has already been read to the jury. Then the following appears:

"Accordingly upon convening Dr. Trible was presented with the following charges, in writing:"

And then follows that letter which the witness called a report, and which Mr. Leahy took exception to.

Mr. Leahy:—I didn't take exception to the letter. I took exception to it being characterized as a report.

Mr. Lewin:—Well, I won't read that again.

Then the report continues:

"Please find herewith attached complete transcript of the proceedings together with one true copy of a business card filed in the office at Children's Hospital.

"In view of the evidence as therein set forth and in particular consideration of the correspondence therein contained as having occurred between Dr. George B. Trible and Dr. Henry Rolf Brown, Medical Director of Group Health Association, Inc., we desire to submit to your committee our verdict of guilty as charged (possibly unwittingly), with the recommendation that such disciplinary measure be in turn recommended to the Medical Society as may seem commensurate with the gravity of the offense.

"Respectfully submitted,
"R. Arthur Hooe, M.D.,
"Chairman, Compensation, Contract and Industrial Medicine Committee."

Mr. Lewin:—Then, in the body of the minutes proper occurs this:

"The compaint against Dr. George B. Trible was taken up at this point."

Oh, yes, at this meeting with Dr. Sprigg, chairman, presiding, there were present:

"Drs. A. B. Bennett, Daniel L. Borden, C. N. Chipman, Harry Lee Claud, A. C. Gray, Raymond T. Holden Jr., Thomas E. Neill, John A. Reed, E. Hiram Reede, Sterling Ruffin, and Mr. Theodore Wiprud, Executive Secretary.

"The minutes of the preceding meeting of April 25 were read and approved.

"Dr. Sprigg then introduced the new Executive Secretary to the Committee. He also introduced Dr. Fred R. Sanderson, representing the Compensation, Contract and Industrial Medicine Committee. The Chairman, Dr. Sprigg said, was unable to attend.

"The executive Secretary then read a letter from Dr. R. Arthur Hooe, Chairman of the Compensation, Contract and Industrial Medicine Committee, and the transcript of the hearing held by the Committee in connection with charges made against Dr. George B. Trible.

"The Chairman stated that Dr. Edith SeVille Coale wished to be heard, and suggested that the complaint against Dr. Trible receive attention later in the meeting. This was agreeable to the Committee."

. . . . . .

"Dr. Sprigg made a brief statement setting forth his views on the behavior of the Doctor.

"Dr. C. N. Chipman reported that Dr. Macon was waiting to be heard.

"The Chairman was rather surprised and said he did not know that either Dr. E. B. Macon or Dr. George B. Trible had been invited to attend.

"Dr. E. B. Macon was invited into the meeting and informed by the Chairman that an error had been made and that the Committee did not desire to hear him. The Chairman apologized for causing him inconvenience.

"Some discussion then followed as to the letter Dr. Macon had received from Dr. C. B. Conklin, informing him that he was to be on hand. This letter was circulated among the Committee.

"Upon Dr. Macon's retirement further discussion was held.

"Motion made by Dr. E. Hiram Reede that the letter directed to Dr. Macon be placed in the record of these minutes and that Dr. Sprigg's comments also be included. Motion seconded by Dr. Holden and carried.

"There followed a discussion as to the advisability of inviting Dr. Trible to a special meeting to be called by the Executive Committee for the purpose of hearing him.

"Dr. A. B. Bennett then stated that he had a letter from Dr. Trible, directed to the Secretary of the Society, also original letters in connection with the complaint which Dr. Trible wished returned to him.

"Dr. Sprigg did not think that this material should be introduced at this meeting. However, Committee members were not in agreement in this matter.

"Motion made by Dr. John A. Reed that the letter directed to the Secretary by Dr. George B. Trible be read. Motion seconded by Dr. Holden and carried.

"Dr. F. X. McGovern requested the privilege of the floor and commented briefly on the letter received from the Compensation, Contract and Industrial Medicine Committee, in which the committee had found Dr. Trible guilty of unethical conduct. He said that the Committee was out of order in passing judgment; that it was merely a fact-finding committee.

"Dr. Trible's letter was read, following which there was considerable discussion.

"Motion made by Dr. Holden that the Executive Committee finds Dr. Trible's explanation adequate and his assurance that he will not in any way knowingly violate the ethics of the profession or the Constitution and By-Laws of the Medical Society in the future satisfactory. For this reason it is their decision that the matter be carried no further; and that Dr. Trible be informed of the Committee's action. Motion seconded by Dr. Chipman and carried.

"There followed a discussion as to whether or not a physician who treats a patient who is a member of the Group Health Association, Inc., as a private case, but accepts payment from the Group Health Association, is guilty of unethical conduct.

"Dr. Sprigg, in a statement based on the information given him by the Society's attorneys, stated that under these circumstances he would be guilty.

"This was denied by Dr. C. N. Chipman who said that the Executive Committee already had gone on record in resolution, stating that such a relationship was not unethical.

"Dr. F. X. McGovern reviewed the past efforts of himself and his Committee to have the Society take a definite stand on the Group Health Association, making its position clear; that so far he had not been successful in getting the Society to act."

Mr. Lewin:—This witness is with you, Mr. Leahy.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Doctor, I show you what purports to be a copy of a letter, and ask you if you can identify that, please. *A.*—It sounds like it. I wouldn't say; I don't remember it.

Q.—You did get a letter from Dr. Sprigg? *A.*—Yes.

Q.—Do you know what you did with that letter? *A.*—No, sir; threw it in the bucket, I think.

Q.—You didn't keep it? *A.*—No.

Q.—This sounds like the letter you received? *A.*—Yes.

Mr. Lewin:—Will you show it to me?

Mr. Leahy:—Yes, here it is.

By Mr. Leahy:

Q.—Well, Doctor, as I understand your testimony, it is this. You were called first by Dr. Hooe before this contract committee? *A.*—Yes.

Q.—You appeared there for a few minutes? *A.*—Yes.

Q.—Everything was very informal? *A.*—Yes.

Q.—And then you were advised by Dr. Hooe that these charges were to be sent on to the executive committee? *A.*—Yes.

Q.—You never even appeared before that committee? *A.*—That is correct.

Q.—You turned your letters over to them? *A.*—Yes.

Q.—And found everything was all right, and that was all? *A.*—Yes.

TESTIMONY OF ELEANOR HALL

DIRECT EXAMINATION

By Mr. Allen:

Eleanor Hall said she is a clerk in the record room, Eastern Dispensary and Hospital and has been for four and a half years. She identified by-laws of the hospital and Dr. J. Rogers Young's handwriting.

TESTIMONY OF ANNA MARY DENNINGER

DIRECT EXAMINATION

Ann Mary Denninger said she is employed by Dr. Jesse T. Mann and identified his signature.

Mr. Kelleher:—Exhibits 309 and 310, is the questionnaire with the name "Casualty" at the top, and it has been identified as having been written by Dr. Young, the defendant, chief of staff of Casualty Hospital:

EXHIBITS 309 and 310

"Questionnaire.

"1. What communication or inquiry has your hospital had from Group Health Association, Inc.?

"None.

"2. What reply has your hospital made to Group Health Association, Inc.?

"None.

"3. Which, if any of the following Doctors are now members of your Medical Staff in any capacity or have privileges to practice in your hospital?

"Dr. Henry Rolf Brown.

"Dr. Allan E. Lee.

"Dr. Mario Scandiffio.

"Dr. R. Stephen Hulburt.

"Dr. Raymond E. Selders.

"Dr. Edmond D. Wells.

"None.

"4. Is your hospital in sympathy with the policies of The Medical Society of D. C.?

"Yes.

"5. Is the entire Medical Staff of your hospital reappointed annually?

"Yes.

"6. Are appointments to the Medical Staff of your hospital approved by the Medical Staff?

"Yes.

"7. What governing body of your hospital finally makes appointments to the Medical Staff?

"Lay Board.

"8. Does your hospital require membership in the Medical Society of D. C. as a qualification for appointments to its Medical Staff?

"Applicant must be qualified for membership in local Society.

"9. What percentage of the entire medical staff of your hospital are members of the Medical Society of D. C.?

"10. Does your hospital require membership in the A. M. A. as a qualification for appointment to its Medical Staff?

"See No. 8.

"11. What percentage of the entire Medical Staff of your hospital are members of the A. M. A.?

"12. Is your hospital a beneficiary of Community Chest funds?

"No.

"13. Will you kindly make any other inquiry that you think might be pertinent at this time?"

Mr. Kelleher:—Exhibit 579 has been identified as the by-laws of Eastern Dispensary and Casualty Hospital. The Government has offered in evidence Article 2, Section 1, which reads as follows:

EXHIBIT 579

"The applicant for membership shall be,"—let me read the whole thing.

"Article 2, Membership.

"Section 1—Qualification.

"The applicant for membership shall be a graduate of a recognized medical school, legally licensed to practice in the District of Columbia, qualified for membership in the Medical Society of the District of Columbia."

Mr. Kelleher:—Exhibits 300 and 301 is the questionnaire with the word "Sibley" at the top. The answers have been identified as having been made by Dr. Jesse T. Mann:

U. S. EXHIBITS 300 and 301

"Questionnaire.

"1. What communication has your hospital had from Group Health Association, Inc.?

"Asking to admit pt. and those pt. be treated by Dr. Selders.

"2. What reply has your hospital made to Group Health Association, Inc.?

"Non-committal reply.

"3. Which, if any of the following Doctors are now members of your Medical Staff in any capacity or have privileges to practice in your hospital?

"Dr. Henry Rolf Brown.

"Dr. Allan E. Lee. Yes.

"Dr. Mario Scandiffio. Yes.

"Dr. R. Stephen Hulburt.

"Dr. Raymond E. Selders.

"Dr. Edmond D. Wells.

"4. Is your hospital in sympathy with the policies of The Medical Society of D. C.?

"Yes.

"5. Is the entire Medical Staff of your hospital reappointed annually?

"No—only twenty-five members of Medical Council.

"6. Are appointments to the Medical Staff of your hospital approved by the Medical Staff?

"Approved by Medical Council.

"7. What governing body of your hospital finally makes appointments to the Medical Staff?

"Recommended by Medical Council and appointed by Board of Directors.

"8. Does your hospital require membership in the Medical Society of D. C. as a qualification for appointments to its Medical Staff?

"No.

"9. What percentage of the entire medical staff of your hospital are members of the Medical Society of D. C.?

"Majority—about 80%.

"10. Does your hospital require membership in the A. M. A. as a qualification for appointment to its Medical Staff?

"No.

"11. What percentage of the entire Medical Staff of your hospital are members of the A. M. A.?

"About 80%.

"12. Is your hospital a beneficiary of Community Chest funds?

"No.

"13. Will you kindly make any other inquiry that you think might be pertinent at this time?"

Mr. Allen:—I wish now to read Exhibit 521, minutes of the regular meeting of the board of directors of the Children's Hospital of the District of Columbia, held Nov. 15, 1937. I will read only the next to the last paragraph on the second page of this minute:

U. S. EXHIBIT 521

"Mr. Drayton read a letter from the Group Health Association with regard to permitting their physicians the courtesy of the Hospital—they not being members of our staff. Mr. Drayton also read a proposed letter from Miss Gibson in answer thereto. The Board approved the proposed letter. Mr. Seal voting present."

I will read the proposed letter attached thereto, date Nov. 15, 1937. It is from Mattie M. Gibson, Superintendent, to William F. Penniman, Group Health Association:

"Dear Mr. Penniman:

"At a meeting of the Board of Directors of the Children's Hospital, held November 15th, I was authorized to reply to your letter of November 8th as follows:

"The Children's Hospital will accept for treatment or hospitalization any patient in need of care, under its charter, rules and regulations.

"This pertains to indigent, semi-indigent, and a very limited number of pay patients—as we have only twenty-seven beds available for pay patients.

"All doctors treating these patients while in the hospital must have staff appointments and be members of local Medical Societies.

"Dr. Raymond E. Sellers has made no application so far for staff appointment."

Mr. Allen:—If it will be satisfactory to defense counsel I will not read Exhibit 359, which is a letter sent by Miss Gibson to Mr. Penniman, dated Nov. 16, 1937. It is quite similar to the one attached to the minutes and approved, with the exception that it doesn't have the word "and be members of the local medical societies."

Mr. Lewin:—Read that paragraph as the letter went to Mr. Penniman.

Mr. Allen:

"All physician treating patients while in the hospital must be members of the Medical or Courtesy Staff, appoints to which are made annually by its Board of Directors after individual examination into the qualifications of applicants by regular hospital channels.

Next I will read Exhibit 522, dated Dec. 6, 1937. It is the minutes of the annual meeting of the incorporators and members of the Children's Hospital of the District of Columbia.

Mr. Lewin:—Before you read that—

THE COURT:—We will stop here.

Mr. Lewin:—I am afraid your Honor if we do we will miss the point. First it is the letter from the District of Columbia Medical Society of December 2, then this by-law.

Mr. Allen:—I will state for the record in this respect that this letter was subpoenaed from the Children's Hospital and it was not produced, but evidence produced against the Medical Society shows it was sent to all the hospitals. I will only read from the center of page 2, the next three paragraphs, this is Exhibit 522:

U. S. EXHIBIT 522

"Upon proper motion, duly seconded, it was unanimously voted to amend Article 33, Medical Staff—of the By-Laws and Rules by adding the following:

"Only physicians, surgeons, and dentists who are licentiates of the District of Columbia and also members of the District Medical Society or ethical body in their locality shall be eligible for appointment to the Medical Staff.

"Physicians, Surgeons, and Dentists not officially connected with the Hospital, but members of their ethical medical societies, may be accorded the privilege of using the facilities of the Hospital as a matter of courtesy for a term that shall continue during the pleasure of the Board of Directors, those accepting such privileges to be known as the Courtesy Staff."

Mr. Leahy:—Was that the annual meeting?

Mr. Lewin:—Yes.

Mr. Allen:—Your Honor, there is one other minute which takes about three short paragraphs. Exhibit 523, dated April 4, 1938, minutes of the meeting of the medical staff of the Children's Hospital. I will read from the fourth paragraph:

U. S. EXHIBIT 523

"Dr. Wall mentioned the letter written by Mr. Drayton to Senator Capper."

Senator Capper is written in handwriting and the words "the newspapers" are stricken out.

"relating to the Group Health situation. Dr. Wall stated that the Board of Directors had supported the Medical Staff in the differences over Group Health.

"Dr. Wall presented a resolution formulated to take care of emergency admissions to the Hospital. It was moved and seconded that this ruling be adopted. After discussion by several members of the Staff, the ruling was adopted.

"Dr. Hagner moved that the Chairman of the Medical Staff get together with the Chairman of the Medical Staffs of other hospitals to adopt uniform rules covering the admission of Group Health patients. Seconded and carried."

Mr. Allen:—And I will say that the rules governing admission of emergency patients is attached thereto, but I will not read it.

MARCH 3—AFTERNOON

TESTIMONY OF MRS. CAROLINE REECE EPPERLEY (RECALLED)

Mrs. Epperly, secretary to the Superintendent of Sibley Hospital, identified records from the hospital. She was also asked to identify some signatures.

TESTIMONY OF MRS. CHARLES HARDIN

DIRECT EXAMINATION

By Mr. Kellcher:

Mrs. Charles Hardin said she was a member of Group Health Association in 1937. She lives in Arlington, Va., and lived there in 1938.

Q.—Do you have a family membership in G. H. A. which entitled your husband to benefits? *A.*—I did.

Q.—Did your husband become ill on June 19, 1938? *A.*—He did.

Q.—Will you tell us the circumstances surrounding his illness, please? *A.*—He had been feeling not very well for about two days, and late Sunday night the pain became more severe and I thought it necessary to call in a doctor.

Q.—What doctor did you call? *A.*—I called in Dr. Solet.

Q.—Why did you call Dr. Solet instead of the Group Health Association?

Mr. Leahy:—Objected to as immaterial.

THE COURT:—Objection sustained.

By Mr. Kellcher:

Q.—Had you ever called Group Health Association before? *A.*—I had not.

Q.—Did Dr. Solet come over to see the patient? *A.*—He did.

Q.—Did you know Dr. Solet before? *A.*—No; I did not.

Q.—Did he examine Mr. Hardin? *A.*—Yes.

Q.—What was his diagnosis?

Mr. Leahy:—I object.

THE COURT:—Objection sustained.

By Mr. Kellcher:

Q.—Did Dr. Solet ask that a surgeon be called in? *A.*—Yes, sir.

Mr. Leahy:—I object.

THE COURT:—Objection sustained.

By Mr. Kellcher:

Q.—Was another doctor called in? *A.*—Yes; he was.

Q.—What was his name? *A.*—Dr. Bachrach.

Q.—What is his specialty? *A.*—I don't know. He is a surgeon.

Q.—What occurred after those two doctors saw the patient? *A.*—They said he had—

Mr. Leahy:—I object to what was said.

By Mr. Kellcher:

Q.—What occurred?

THE COURT:—Counsel means, what did they do? *A.*—He was taken to the hospital for an emergency operation.

By Mr. Kellcher:

Q.—What hosptial? *A.*—Sibley.

Q.—Sibley Memorial Hospital? *A.*—That is right.

Q.—Before leaving the house did you make a telephone call? *A.*—I did.

Q.—Whom did you call? *A.*—My brother.

Q.—Was your brother also a member of Group Health Association? *A.*—Yes; he was a charter member.

Q.—Did you meet your brother at the hospital? *A.*—I did. I asked him to come there.

Q.—Did you meet him there? *A.*—Yes.

Q.—Was Mr. Hardin operated upon? *A.*—Yes; he was.

Q.—Prior to the operation did you have a telephone conversation with Dr. Selders from the hospital? *A.*—Yes; I did.

Q.—Dr. Selders was the Group Health Surgeon? *A.*—That is right.

Q.—Will you tell us whether Dr. Selders made any suggestion about—

Mr. Richardson:—Just a minute, please.

Mr. Kelleher:—Let me ask the question.

Mr. Richardson:—The question is leading and suggestive.

THE COURT:—Do not answer that question until I rule on it. You may finish the question.

By Mr. Kelleher:

Q.—Can you tell us whether Dr. Selders made any statement about moving the patient from Sibley Memorial Hospital?

Mr. Leahy:—I object.

THE COURT:—Objection sustained.

By Mr. Kelleher:

Q.—Was the patient operated on in Sibley Memorial Hospital? *A.*—He was.

Q.—By whom? *A.*—Dr. Bachrach.

Q.—Who authorized Dr. Bachrach to operate upon your husband?

Mr. Leahy:—I object, as immaterial.

THE COURT:—Objection sustained.

By Mr. Kelleher:

Q.—After your husband had been operated upon and after he had recovered, what instructions did you leave at the office of Sibley Memorial Hospital as to the bill?

Mr. Leahy:—I object, as immaterial.

THE COURT:—Is this one of those cases referred to in the letters between Group Health and certain physicians?

Mr. Kelleher:—No, your honor. But this is another instance—

THE COURT:—Maybe you had better step here.

(Counsel for the respective parties approached the bench.)

(Counsel resumed their places):

By Mr. Kelleher:

Q.—I will repeat the last question which I asked you. What instructions, if any, did you give the cashier of the hospital concerning your hospital bill after your husband had recovered from his operation? *A.*—I asked that she send the bill to Group Health Association, of which I was a member.

Q.—What was her response? *A.*—She said that she had contracted with me and not with Group Health, and therefore it was my bill, and she had nothing to do with Group Health.

Q.—How did you pay the bill? *A.*—I went to the president of Group Health Association, Mr. Kirkpatrick, who had asked me to have the bill sent to him—

Mr. Leahy:—I object to any conversation.

By Mr. Kelleher:

Q.—Just tell the jury how you paid the bill. *A.*—In cash, which Mr. Kirkpatrick gave me.

Mr. Kelleher:—That is all—with the privilege of recalling the witness.

Mr. Leahy:—No questions.

THE COURT:—She may remain.

Mr. Kelleher:—Will you remain until after your brother takes the stand, please?

The Witness:—Yes.

(The witness left the stand and retired to the witness room.)

TESTIMONY OF SHERWOOD K. BOOTH

DIRECT EXAMINATION

By Mr. Kelleher:

Sherwood K. Booth said he lives in Arlington, Virginia.

Q.—Were you a member of Group Health Association in June, 1938? *A.*—I was.

Q.—On June 19, 1938, did you receive a telephone call from your sister? *A.*—I did.

Q.—What did you do as result of that call? *A.*—As a result of that call I went to the Sibley Hospital to see my sister and my brother-in-law who was going there for an emergency operation for appendiciits.

Q.—What was the name of your sister? *A.*—Mrs. Charles G. Hardin, Jr.

Q.—Will you tell us what occurred at the hospital when you arrived there? *A.*—I arrived at the hospital just a minute or so before my sister and my brother-in-law arrived there, and immediately upon their arrival I spoke to the night supervisor or the night superintendent—anyway, the person in charge—and her name was Miss Realini—to ascertain whether a Group Health surgeon would be permitted to operate on my brother-in-law. Miss Realini replied that Group Health—

Mr. Leahy:—I object to that, if your Honor please.

THE COURT:—Objection overruled. Can you identify the doctor in the case, if a doctor's name was mentioned?

Mr. Leahy:—Some young lady, he is talking about.

THE COURT:—This gentleman said that he inquired of this lady about the Group Health doctor. I was wondering whether the name of a particular doctor was mentioned.

By Mr. Kelleher:

Q.—Was the name of a particular doctor mentioned? *A.*—Yes; it was.

Q.—What was the name of the doctor? *A.*—The name of the doctor was Dr. Selders, who was at that time the chief surgeon on the staff of Group Health Association.

Q.—Will you continue with your testimony concerning this conversation with Miss Realini? *A.*—As soon as my brother-in-law arrived there I immediately went to the desk on his behalf to find out whether it would be agreeable to the hospital to have Dr. Selders operate on him. Miss Realini replied that she was very sorry, but that Group Health doctors were not permitted to operate in that hospital. I explained to her the emergency of the case, but from the circumstances she was well aware of that. But she said it did not make any difference whatsoever, regardless of the events; she was terribly sorry, but she was without authority to permit a Group Health doctor to come in there.

I mentioned the fact that Dr. Selders was the name of the doctor who was to do the operating. She again reaffirmed her previous statement and, as I recall, she had a slip of paper on the desk, on her side of the desk, and she referred to that, and upon doing so she again stated that she was awfully sorry, but Dr. Selders would not be permitted to operate.

Q.—Then what did you do, after this conversation? *A.*—Thereupon I, in her presence, immediately called up Dr. Selders on the telephone and explained the circumstances to him in the hope that—

Mr. Leahy:—I object.

THE COURT:—Just tell us what was said.

The Witness:—I called Dr. Selders on the 'phone, explained the circumstances to him, and that we wanted him to operate in this case, and in reply he stated—

Mr. Leahy:—I object to the conversation.

THE COURT:—Was the substance conveyed to this lady?

The Witness:—It was.

THE COURT:—I think you might state what you stated to the lady as coming from the doctor.

The Witness:—I mentioned to Dr. Selders that we would like—

Mr. Leahy:—I object to that. Just tell what you told the lady.

By Mr. Kelleher:

Q.—Did Dr. Selders request to speak to anybody?

THE COURT:—No. He can state what he reported to Miss Realini as to what Dr. Selders said.

After having this conversation, what did you report, if anything, to this lady?

The Witness:—I mentioned to Miss Realini that Dr. Selders said he could come there in ten minutes and operate on the patient. Thereupon Miss Realini replied that she was terribly sorry but, as she said before, he could not operate. Thereupon Dr. Selders asked me over the 'phone to hand the 'phone to Miss Realini.

Mr. Leahy:—I object.

THE COURT:—Yes. It is the conversation between these two people that should be given.

By Mr. Kelleher:

Q.—Did you tell Miss Realini that Dr. Selders wanted to speak to her? *A.*—Yes.

Q.—Did she take the telephone and speak to Dr. Selders? *A.*—Yes. I was sitting in front of Miss Realini and I handed the 'phone over to her and she spoke to Dr. Selders in my presence.

Q.—What did she say? *A.*—She told Dr. Selders, in a very congenial way, but very firmly, that she was terribly sorry, but

that he would not be permitted to operate in that hospital, being a Group Health doctor.

Q.—Did she have this slip of paper which you mentioned before? *A.*—She did. She still had that in front of her.

Q.—Was there anything more said? *A.*—I don't think so. The conversation, of course, was between them, and I heard her end of the conversation.

Q.—After this conversation did you receive another telephone call? *A.*—Yes. The 'phone was no more than hung up and it rang again and it was Dr. Selders calling back and he asked to speak to me.

Q.—Did you speak with him? *A.*—I did.

Q.—Did you tell Miss Realini what Dr. Selders said on this occasion? *A.*—I did.

Q.—Will you tell us what you told Miss Realini Dr. Selders said? *A.*—Yes. I told Miss Realini that Dr. Selders called again wanting to discuss the advisability of having the patient moved to Casualty Hospital; that Dr. Selders had told me that if the patient were moved there there was a reasonable likelihood that he could operate on the patient at Casualty Hospital he was not sure, but he thought he might be able to make such arrangements.

Q.—What did Miss Realini say? *A.*—Miss Realini did not have much to say. Of course she understood it was—

Mr. Leahy:—I object to the conclusion.

THE COURT:—What did she say?

The Witness:—She had nothing more to say to that except that I mentioned to her that I was awfully sorry that the Group Health doctor could not operate, and she again explained her position, that she was the night supervisor of the hospital, but she had her orders as to those who were on the courtesy list, and she was sorry, but there was nothing she could do about it.

By Mr. Kelleher:

Q.—Did your sister talk with Dr. Selders over the telephone? *A.*—She did.

Q.—Was that in your presence and in the presence of Miss Realini? *A.*—That was in the presence of both of us; yes.

Q.—What did your sister say? *A.*—This was the second 'phone call with Dr. Selders, and my sister explained to Dr. Selders the situation, that the doctors had told her that he should be operated on immediately and that they were taking his blood count and preparing him for the operation, for whoever would operate on him, and explained to Dr. Selders the situation so he would realize the fact that it would not be reasonable to move the patient.

Q.—And in the presence of you and Miss Realini did she take any position one way or the other as to moving the patient from Sibley Memorial Hospital to Casualty?

THE COURT:—He has just said that. The witness just said she explained to Dr. Selders that the case was too urgent to consider moving him.

Is that about the substance of it?

The Witness:—Yes, your Honor.

By Mr. Kelleher:

Q.—Had you employed Dr. Bachrach to operate upon the patient prior to these telephone calls that you have just testified about? *A.*—I did not.

Q.—After these telephone calls did you authorize Dr. Bachrach to perform the operation? *A.*—Not specifically, for the reason that I was the brother-in-law of the person who was to be operated on. The final authorization naturally would be given by my sister, who was his wife.

Q.—Did she give that authorization? *A.*—After she talked to Dr. Selders the second time she went up and gave that authorization. However, I went upstairs also and stated to Dr. Bachrach that inasmuch as the Group Health doctor was not—

Mr. Leahy:—I object to the conversation.

THE COURT:—Yes. I think it is merely a question of whether Dr. Bachrach was to operate.

By Mr. Kelleher:

Q.—Do you know whether your sister had authorized Dr. Bachrach to operate upon the patient prior to these telephone calls with Dr. Seiders? *A.*—I know she did not. It was understood, however, from my conversation with my sister, that this doctor, Dr. Bachrach, would be given the authority to operate in the event that we were unsuccessful in having the hospital's permission to have a Group Health doctor operate.

Mr. Kelleher:—That is all, Mr. Leahy.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Did you know Dr. Bachrach personally? *A.*—I did not.

Q.—Did you know that your brother-in-law was sick before you were notified by 'phone to that effect? *A.*—I did not.

Q.—As I understand it, then, you got a telephone message that your brother-in-law was sick and was at Sibley Hospital? *A.*—No. I received a telephone message on Sunday evening about 11 o'clock from my sister to the effect that they were leaving immediately to go to Sibley Hospital; that they had called in a local doctor; my brother-in-law was severely ill and they had called in a local doctor and found out it was appendicitis, and the doctor had advised her that he would have to be operated on immediately, and therefore she asked me—

THE COURT:—I do not think we need all these details.

By Mr. Leahy:

Q.—What time was it when you got to the hospital, as you recall? *A.*—I don't recall specifically the time, but I do know it was close to midnight on Sunday.

Q.—When you got there who was with your brother-in-law? *A.*—When I got there nobody was with my brother-in-law.

Q.—How long were you there before your brother-in-law came? *A.*—About a minute or two.

Q.—When he came who was with him? My sister; and at the same time Dr. Solet came in. I believe he had brought them over.

Q.—Any other doctor? *A.*—Concurrently this Dr. Bachrach came in, but I don't believe that he came along with them. I could not testify to that.

Q.—Was Dr. Bachrach there within a minute or two or three minutes? *A.*—He was there very, very shortly; yes.

Q.—In other words, it looked as though Dr. Bachrach, Dr. Solet, your sister and her husband all got there about the same time? *A.*—Approximately the same time. However, I believe that Dr. Solet and my sister and my brother-in-law were there first. Of course this was three years ago, and it is pretty hard to remember all the details.

Q.—But there was not any appreciable length of time? *A.* No, sir.

Q.—In fact, while you were downstairs talking on the telephone Dr. Bachrach and Dr. Solet were up taking your brother-in-law's blood count, were they not? *A.*—I don't know what they were doing. I know they were upstairs.

Q.—Did you not say they were getting ready for the operation at that time? *A.*—That is right.

Q.—And Dr. Bachrach, while you were there talking to Dr. Selders, was upstairs with your sister and your brother-in-law? *A.*—That is right.

Q.—Did Miss Realini— *A.*—Excuse me. I am not sure that the doctor was with my brother-in-law. All I know is that they were all upstairs.

Q.—You got word, did you, that they were preparing the operating room and taking his blood count and things of that sort? *A.*—That is correct.

Q.—In fact, you got word that the operation was so imminent at the time that you did not feel that he should be moved from one hospital to the other? *A.*—That is correct.

Q.—Was Miss Realini—was that the name of the young lady with whom you were speaking? *A.*—Yes; it was.

Q.—Did you say she was night superintendent? *A.*—She was the nurse in charge in the evening. Her title was Night Supervisor or Night Superintendent. She was the person in charge.

Q.—When you chatted with her and asked her whether or not Dr. Selders could operate in Sibley Hospital, she told you that she was awfully sorry, but that he was not on the courtesy staff? *A.*—That is right, and she further stated that being a Group Health doctor he could not operate there.

Q.—She also stated to you that he was not on the courtesy staff? *A.*—That is correct.

Q.—Did you know whether or not he was on the courtesy staff before you went to the hospital? *A.*—I didn't; no. I had reason to feel, however—

Q.—Well, you did not know? *A.*—I did not know.

Q.—Do you know whether your sister knew whether he was on the courtesy staff when she went to the hospital?

Mr. Kelleher:—I object. How would this witness know that?

By Mr. Leahy:

Q.—Just yes or no. *A.*—Will you repeat that question, please?

Q.—Do you know whether or not your sister knew whether Dr. Selders was on the courtesy staff of Sibley when your brother-in-law went there? *A.*—She did not know, to my knowledge.

Q.—Did you know Dr. Solet before that evening? *A.*—I did not.

Q.—Is he a doctor in Arlington? *A.*—He was at that time, I understand.

Q.—Do you know whether or not he is still there? *A.*—I really don't know.

Q.—Dr. Bachrach operated on your brother-in-law, did he not? *A.*—That is correct.

Q.—And he was out in four or five days, was he? *A.*—In about a week's time, I believe. I am not sure as to the time.

Mr. Kelleher:—We now offer in evidence Exhibits 580, 581 and 582, which are the hospital records in the Hardin case.

THE COURT:—Very well. Are there any objections to these?

Mr. Leahy:—No special objection; no.

U. S. EXHIBIT 580

Mr. Lewin:

"SIBLEY MEMORIAL HOSPITAL
PATIENT'S RECORD

"Adm. No. 128467
"Adm. Date 6-19, 1938, at 11:45 P. M.
"Dis. No. G 3724
"Dis. Date 6-25-38
"Name Mr. Charles Hardin Rm. No. 201 M
"Street and No. 212 N Piedmont St. Arlington, Va.
"Occupation Salesman Age 25 Nationality Miss.
"Reference Mrs. Helen Hardin Relationship Wife
"Street and No. 1
"Doctor Bachrach Admitted by M. Realini
"DIAGNOSIS: Acute appendicitis
"Condition on Discharge Improved
"Operation: Appendectomy
"Record prepared by Menke, Intern
"Edited and approved Leo Solet, M.D. Attending Physician."

U. S. EXHIBIT 581

Mr. Lewin:

"SIBLEY MEMORIAL HOSPITAL
OPERATIVE RECORD

Case No. 128467
Date June 20, 1938

Name Mr. Charles Hardin Location 201M
Preoperative Diagnosis: Appendicitis
Postoperative Diagnosis: Same
Surgeon Dr. Bachrach
Anesthetist Dr. Katzman
Assistants Dr. Menke—Varner
Instrument Nurse Miss Kinsey
Suture Nurse Miss Kinsey
Anesthetic: gas—ether
Operation: Began 12:15 A. M. Closed 1:10 P. M.
Condition during anesthesia: Good
Immediate postoperative condition: Good
Operation: Appendectomy

Signature of Operator
L. Bachrach"

U. S. EXHIBIT 582

Mr. Lewin:

"SIBLEY MEMORIAL HOSPITAL
Pathological Laboratory

REPORT OF EXAMINATION OF TISSUE

For Dr. Bachrach Patient's name Mr. Charles Hardin
Date 6-23-38 Date received 6-20-38
Hospital Number 128467 Lab. Number 16467
Material Appendix 201 M
Clinical Diagnosis or comment Acute appendicitis
Sections: Frozen
Embedded

DIAGNOSIS: ACUTE CATARRHAL APPENDICITIS
TISSUE DESCRIPTION:

The appendix is highly congested and covered with dilated vessels as well as tortuous ones of long standing. The organ measures 8 cm. in length by 0.9 cm. in diameter and on section cuts with slight resistance revealing an ovoid, broadly dilated lumen filled with catarrhal exudate. The mucosa is partially eroded and the submucous and muscular coats are thickened and edematous. The picture presented is that of an acute exacerbation of a chronically inflamed organ.

Reported:
Oscar B. Hunter, M.D., Pathologist"

TESTIMONY OF JAMES ROBERT ADAMS

DIRECT EXAMINATION

By Mr. Kelleher:

James Robert Adams said he knows Miss Elizabeth Tew who in 1938 lived at 2127 California Street Northwest.

Q.—Will you tell the jury what occurred on the evening of Feb. 26, 1938? *A.*—About 7 o'clock in the evening I had a telephone call requesting that I go with Miss Tew and Miss O'Connor to the hospital. It seems that she had been seriously ill and it was necessary to go to the hospital under the doctor's orders. So I proceeded to dress and called a cab.

Q.—Where did she live? *A.*—Apartment 315, I believe it was; the same apartment house. I called a cab and assisted Miss Tew to the elevator and out into the cab and over to the hospital, and while arrangements were being made for her entry into the hospital I held Miss Tew and supported her and took her upstairs to the room assigned to her.

Q.—What hospital was this? *A.*—Garfield. I remained in the room for a few minutes and left the room while they prepared Miss Tew for bed. During that time I was outside in the lobby or the corridor of the hospital. I later reentered the room, after she had been placed in bed, and an intern came in and made an examination, at the time taking her blood pressure and asking questions. Some of them I did not overhear. I stayed there until about 8 o'clock, and along about 8:15 they gave her an injection of morphine and I remained in the room until about 10 o'clock, at which time Dr. Selders and Miss O'Connor came back into the room and said that the operation would not be performed that night. Shortly after that Dr. Dugan, another doctor, and a nurse came into the room and said that the privileges of the hospital had not been extended—

Mr. Leahy:—I object.

By Mr. Kelleher:

Q.—Who was Dr. Dugan? *A.*—I thought he was a hospital physician.

Mr. Lewin:—It is already in evidence that he was the assistant resident in surgery at Garfield Hospital at that time.

By Mr. Kelleher:

Q.—Will you now tell us what Dr. Dugan said? *A.*—Dr. Dugan said that the privileges of the hospital had not been extended to Dr. Selders, since he was a member of the Group Health Association, and that the operation could not be performed by Dr. Selders. He extended the facilities of the staff of Garfield Hospital. Miss Tew refused any of the staff surgeons.

Q.—What suggestion did Dr. Dugan make in that connection? *A.*—He asked at that time if Miss Tew would sign a release in order to leave the hospital. Upon advice she refused to sign a release, and then the release was read.

Q.—After Miss Tew had received the injection of morphine did she lose consciousness? *A.*—She lost absolute consciousness for about thirty minutes. Otherwise she was in what I would call a semi-stupor.

Q.—Was she conscious when Dr. Dugan came into the room? *A.*—She was in a stupefied condition.

Q.—Have you testified whether Miss Tew signed or declined to sign a release? *A.*—She refused to sign a release.

Q.—I show you Government Exhibit 584 for identification and ask you if you can identify that as the release which Dr. Dugan requested Miss Tew to sign. *A.*—I cannot identify it by the paper, but I can by the language of it.

Q.—Was it read out loud in your presence? *A.*—It was.

Q.—What occurred after Dr. Dugan left the room? *A.*—I went down to see Dr. Selders who was present and asked if he could—

Mr. Leahy:—I object to any conversation.

A.—(Continuing). It was the request of the doctor—

THE COURT:—Just a moment.

By Mr. Kelleher:

Q.—Just tell us what occurred in Miss Tew's room. *A.*—It was nothing, except she remained in a stupefied condition until about 11 o'clock, when Dr. Dugan returned.

Q.—What did Dr. Dugan say when he returned? *A.*—He again offered the services of the staff and suggested to Miss Tew that she secure the services of another surgeon before being operated on by Dr. Selders. We remained there until about 12 o'clock, at which time I left the room long enough for Miss Tew to be dressed and then took her down the hall, leaving the hospital. The nurse came with a wheel chair and took her to the front door. In the meantime a cab had been called and was waiting for us. It was necessary to set Miss Tew upon the steps of the hospital before putting her into the cab. She was in more or less of a nauseated condition and was unable to make the effort even to get into the cab.

Q.—How long did she stay out on the steps of the hospital? A.—About ten to fifteen minutes at least.

Q.—Was it a cold night? A.—It was very cold. The cab was heated, and we immediately proceeded back to 2127 California Street, but she was unconscious on the ride and remained in a stupefied condition until we got back there and she was assisted into her apartment, and while she was being prepared for bed I was in the kitchen cracking ice upon recommendation of the physician that an ice-bag be placed upon her.

CROSS EXAMINATION

By Mr. Leahy:

Q.—You stated that you had received a telephone call to go up to Miss Tew's apartment. Who was it that 'phoned you? A.—Miss Davis or Miss O'Connor.

Q.—Did you know Miss O'Connor? A.—Yes, sir.

Q.—How long have you known Miss O'Connor? A.—Since 1936.

Q.—How long have you known Miss Davis? A.—Miss Davis and Miss O'Connor are the same person.

Q.—Is it Mrs. O'Connor? A.—It was Mrs. I believe it is now Miss Davis; and at one time she was known as Miss O'Connor around the office where she worked.

Q.—In what office did she work? A.—Work Projects Administration.

Q.—Is that the place you worked in? A.—Yes.

Q.—In what capacity did you work there? A.—Junior Administrative Assistant.

Q.—To whom? A.—To Frank A. March, Director of the Project Control Division.

Q.—Had you known Miss Tew before? A.—I became acquainted with Miss Tew through Miss Davis, about a year or a year and a half before that; I think it was about a year

Q.—Did you know Miss Tew pretty well? A.—Yes, sir.

Q.—Were you going with her? A.—No, sir.

Q.—Just a friend? A.—Yes.

Q.—Had you ever called on her before? A.—No, sir.

Q.—Just saw her around the office working? A.—Miss Tew did not work in the W. P. A., sir.

Q.—Did you just see her in the apartment house? A.—Yes, sir.

Q.—But you had never been friendly with her in the sense that you had called at the apartment? A.—She and Miss Davis had an apartment together at one time at 2000 Connecticut Avenue and also, later on, at 2127 California Street, and I visited the apartment at both places.

Q.—Miss Davis is the one who called you on the 'phone and asked you to go up to Miss Tew's apartment? A.—Yes.

Q.—She was not living then with Miss Tew? A.—Yes.

Q.—So Miss Davis called you from Miss Tew's apartment to come up? A.—Yes.

Q.—And asked if you were going to the hospital; is that right? A.—That they were going to the hospital, and asked if I would go over with them.

Q.—About what time was that? A.—About 7 o'clock in the evening, sir.

Q.—You were not in bed then, were you? A.—No, sir.

Q.—What date was it; do you remember? A.—Feb. 26, 1938.

Q.—Did they say what hospital they were going to? A.—After I got up there they told me they were going to Garfield.

Q.—Who had made the arrangements; do you know? A.—I was not present when the arranagements were made, sir.

Q.—You did not know who it was until you started for Garfield? A.—I understood that Dr. Selders had made the arrangements.

Q.—Who told you about that? A.—Miss Davis.

Q.—And you then went over to Garfield Hospital with Miss Tew? A.—Yes, sir.

Q.—Did you know Dr. Selders personally? A.—No, sir.

Q.—Had you ever seen him before that night? A.—I don't believe I had.

Q.—Were you familiar at all with the rules and regulations of this hospital? A.—To the extent that you have to be entered; that privileges are extended to outside doctors who are not on their staffs if they conform to the rules and regulations.

Q.—Did you know anything about the courtesy staff at the hospital? A.—No, sir.

Q.—Now, who entered Miss Tew at the hospital, the Garfield Hospital? A.—Miss Davis for Group Health group hospitalization. She had both cards. Miss Tew was a member of both organizations.

Q.—To whom were those credentials submitted? A.—I believe to the nurse at the entrance desk.

Q.—Now that nurse at the entering cage saw that she was a member of Group Health Association? A.—Yes.

Q.—And no question was raised at that time by her as to being a member of Group Health Association? A.—No, sir.

Q.—She was immediately assigned to a room? A.—Yes.

Q.—And preparations immediately begun to take care of her for an operation? A.—Yes.

Q.—Did you see any injection given to her? A.—Yes, morphine.

Q.—Did you see the intern give her that? A.—Yes.

Q.—Do you know who that intern was? A.—I couldn't tell his name.

Q.—Did you hear his name that night? A.—I thought Dr. Dugan. There were two interns that came in there in my presence. I don't know whether it was Dr. Dugan. I do know it wasn't the first intern that came in. I didn't hear either name mentioned prior to 10 o'clock.

Q.—Do you know which one it was that gave the injection? A.—The second one.

Q.—Was that Dr. Dugan? A.—I do not know, sir.

Q.—Do you know Dr. Dugan? A.—I heard his name given at 10 o'clock, as Dr. Dugan.

Q.—Was the man whom you heard referred to as Dr. Dugan the one that you saw giving the injection earlier? A.—I presume so.

Q.—And did he make an examination of Miss Tew? A.—Yes.

Q.—Do you recall when it was that he made this examination at Miss Tew's bedside, a half hour, an hour, or an hour and a half earlier? A.—I recall two examinations. One when the intern or doctor came in there; presumably an intern because he was dressed in hospital white. He took her blood pressure and asked her some questions. There was a second one who came in and made a more or less superficial examination of her.

Q.—Was that Dr. Dugan? A.—I am not positive.

Q.—Do you remember when you first saw the individual whom you later learned was Dr. Dugan? A.—Will you repeat your question?

Q.—Do you remember when you first saw the person whom you later learned was Dr. Dugan? A.—I believe I first saw him down in the room prior to 10 o'clock. I presume he was the one that gave the injection.

Q.—When was it that you first saw Dr. Selders there? A.—He met us in the lobby of the hospital and he immediately left to prepare himself for the operation.

Q.—He met you in the lobby at what time? A.—It was about 7:30 or 7:45 when we arrived there.

Q.—When did you see him the second time? A.—I didn't see him a second time until he came in the room about 10 o'clock.

Q.—And at that time was Dr. Dugan in the room? A.—Not immediately. Dr. Selders and Miss Davis came in first. Dr. Dugan and another doctor, whom I did not know by name, and a nurse, followed within a few minutes.

Q.—How many minutes do you mean, two or three? A.—That is all.

Q.—And that is when you heard Dr. Dugan say that Dr. Selders was not on the staff? A.—Yes.

Q.—And he couldn't operate because he was not on the staff? A.—Yes.

Q.—And Dr. Dugan said, "You can have anyone on the staff of Garfield to operate? A.—Yes.

Q.—And at that time Miss Tew said, "No"; she wouldn't take anybody from the staff of Garfield? A.—Correct.

Q.—Were any names mentioned of doctors on the staff? A.—I believe there might have been one or two names of staff physicians.

Q.—You can't recall them now? A.—No.

Q.—How long do you think this conversation lasted in the room, when Dr. Dugan said you can have anybody on the staff of Garfield for the operation? A.—I doubt if it was much more than five minutes; it was at least five minutes but hardly much more than that.

Q.—Was that the time also that Dr. Dugan said he would like to have her sign the release? A.—Yes.

Q.—He told her it was perfectly all right for her to remain in the hospital, but that Dr. Selders, not being on their staff, couldn't operate there in the hospital? A.—I don't know that he made that statement; I don't remember.

Q.—Do you know why it was he asked her to sign the release? A.—I presume he wanted it in case anything happened. She was going to leave and he wanted the release because she told him she was going to leave, to free them of responsibility in case anything happened to her.

Q.—In other words, she said she was leaving the hospital; she would leave the hospital before she would permit any other member of the staff to operate on her? A.—I wouldn't remember whether she said that.

Q.—Didn't she say she would leave the hospital; that she would not permit any other doctor on the Garfield staff to operate on her? *A.*—She said she would not leave one of the doctors operate, if necessary she would leave the hospital. And she proceeded to leave the hospital.

Q.—How long after that? *A.*—Two hours.

Q.—And before she left the hospital did Dr. Dugan then say to her, "You can have anybody on the staff operate on you"? *A.*—That is right.

Q.—And she again said, "No," she would leave the hospital? *A.*—Yes.

Q.—Did Dr. Dugan advise her not to leave the hospital? *A.*—No, sir, I don't think he did.

Q.—Did he read over what he wished Miss Tew to sign? *A.*—He read aloud the release.

Q.—What? *A.*—He read aloud the release.

Q.—Do you remember that as he read the release you heard him say, as to the statement which was contained in the release, "I hereby acknowledge Miss Elizabeth Tew is leaving the Garfield Memorial Hospital against the advice of the attending physician, and that I assume no responsibility for the risk in so doing." Do you remember that? *A.*—If that is the language that I just saw in this document here, then that is what he read aloud.

Q.—Don't you remember that he advised against her leaving the hospital? *A.*—No, sir.

Q.—Do you remember any conversation that took place there? *A.*—That was about all the conversation amounted to; the fact that he came in and said that the privileges of the hospital had not been extended to Dr. Selders, and Dr. Selders could not operate; and then, on request, he read the release aloud. He asked her to sign the release first. She refused to sign the release, and then the release was read aloud.

Q.—Who told her not to sign it? *A.*—Dr. Selders and Miss Davis.

Q.—Dr. Selders was there all the time while this was going on? *A.*—Yes.

Q.—Do you remember about what time this was? *A.*—Just about ten o'clock.

Q.—Who is Miss Ruby M. Marsh? *A.*—I don't know her, sir.

Mr. Leahy:—Have we that report, Exhibit 488 in evidence?

Mr. Lewin:—No, it has not been offered in evidence yet.

By Mr. Leahy:

Q.—How long after this incident about her refusing to sign this release was it that she left Garfield Hospital? *A.*—About two hours.

Q.—So it was about midnight? *A.*—Yes.

Q.—Was it Miss Marsh that obtained for her the chair you spoke about? *A.*—I don't know her name, other than that she is a nurse, and a nurse obtained the chair.

Q.—You say she went outside? *A.*—Yes.

Q.—And it was a cold night? *A.*—Yes.

Q.—And she was on the porch? *A.*—Sitting on the steps of the hospital about ten or fifteen minutes.

Q.—Who was with her then? *A.*—Miss Davis and myself.

Q.—Had you ordered a cab? *A.*—We were proceeding to leave the hospital—the cab was waiting there. Miss Tew left the wheel chair at the door of the hospital. She got out there, and she was unable to go any further. She stayed on the steps there for ten or fifteen minutes.

Q.—Did you ask anybody to go back in the hospital with her? *A.*—No, sir.

Q.—You just sat there with her? *A.*—I was not sitting.

Q.—Was the cab waiting there in front of you? *A.*—Yes.

Q.—You didn't try to help her in the cab? *A.*—I was unable to get her in. She was nauseated and felt she was going to be sick.

Q.—Was she? *A.*—No, sir.

Q.—Did you get her home? *A.*—Yes.

Q.—What time did you reach home? *A.*—Ten or fifteen minutes later.

Q.—Was she able to get out of the cab? *A.*—We assisted her into the house and up to her apartment.

Q.—Did she have to sit on the apartment house steps ten or fifteen minutes? *A.*—No, sir.

Q.—She was able to get into her apartment? *A.*—With support.

Q.—Did you remain in that apartment that evening? *A.*—Yes.

Q.—How long did you remain there? *A.*—I would not want to say. I went out while Miss Davis was preparing her for bed, went out for some cracked ice in the kitchen.

Q.—Who was it said to crack the ice? *A.*—Dr. Selders had said that an ice pack should be given to her.

Q.—Was that while you were all up in the room? *A.*—No, sir; Dr. Selders returned to the room before he left the hospital.

Q.—Do you recall whether the intern came back at all into that room that night? *A.*—I don't recall anyone other than the group, as I have mentioned them, that came in after Dr. Selders and Miss Davis, about ten o'clock, and Dr. Dugan returning later. I don't recall any other intern coming in there.

Q.—You said something with reference to a doctor having made a suggestion that Miss Tew have another examination. *A.*—That was Dr. Dugan, about 11 o'clock. At that time he re-offered the facilities of the staff, and he made that suggestion.

Q.—You remember just before you left what he said? *A.*—He suggested that in any event that she should secure the services of another physician and surgeon.

Q.—Did he say "another physician and surgeon" or another examination? *A.*—He said another physician and surgeon.

Q.—You remember that distinctly? *A.*—Yes.

Q.—Did you go with Miss Tew when you brought her to her apartment that night? *A.*—Yes.

Q.—What time did you leave her apartment? *A.*—Approximately about a half hour, perhaps.

Q.—And she then had with her Miss O'Connor? *A.*—Yes.

Q.—And that is the end of it, so far as you know? *A.*—That was the end of it so far as that night was concerned.

TESTIMONY OF PEGGY O'CONNOR

By Mr. Kelleher:

Miss Peggy O'Connor, sometimes known as Miss Davis, said she lived with Miss Elizabeth Tew in February of 1938. Miss Tew became ill during that month, on the 19th.

Q.—What did you do when you learned she was ill? *A.*—I think I met her after work. She was at home in bed. I first called the Group Health medical doctor.

Q.—Was Miss Tew a member of that organization? *A.*—Yes, and later the medical doctor called the surgeon. He felt it was a case that called for an operation, and they in turn called Dr. Selders in that evening.

Q.—What was the name of the doctor? *A.*—That I can't recall.

Q.—Was it Dr. Richardson. *A.*—I can't recall.

Q.—But the surgeon was Dr. Selders? *A.*—Yes.

Q.—What occurred after that? *A.*—He made a thorough examination and said—

Mr. Leahy:—I object to what he said.

THE COURT:—Sustained.

The Witness:—She had an acute case of appendicitis.

Mr. Leahy:—Same objection

THE COURT:—Do not repeat the conversation.

By Mr. Kelleher:

Q.—Was it on the 19th of February when she first became ill? *A.*—She became ill, I think, it was on a Saturday afternoon. I met her at work and took her home. On Sunday he was called in, this medical doctor, and the surgeon was called in within an hour after he came, and made this medical examination. He then stated that—

Mr. Leahy:—Objection.

Mr. Kelleher:—Don't tell us what Dr. Selders said.

By Mr. Kelleher:

Q.—After Dr. Selders saw her what occurred, do you know? What did you do and what was done? *A.*—He put an ice pack on her stomach and side.

Q.—Did she go to the hospital that night? *A.*—No, she remained there in the apartment four or five days, the exact number of days I am not sure about.

Q.—And then was Dr. Selders called again? *A.*—Yes, he was in to see her every day and the case had subsided, that was the statement he made.

Q.—And after he had seen her through the latter part of the week, what did you and Miss Tew do? *A.*—She became worse. I called someone at Group Health headquarters, someone connected with it at that time, and told them I thought something should be done. She had been lying there with soups and liquids and water, and I thought something should be done.

Q.—On February 26, did you and Miss Tew go to Garfield Hospital? *A.*—Yes, we did at Dr. Selders' direction.

Q.—Who arranged for the admission? *A.*—Dr. Selders.

Q.—Did you have any negotiations at the desk? *A.*—Yes, I did.

Q.—What were they? *A.*—I had credentials showing she was a member of Group Health. She was admitted and the room assigned to her. I took her to a room, Miss Marsh, the nurse and I.

Q.—Both of you? *A.*—Yes.

Q.—And were you there when an intern examined her? *A.*—Yes, I saw him talking with her about the case for a couple of minutes and then another doctor came in, I think Dr. Dugan.

Q.—What did he do? *A.*—He gave her a thorough examination—about a three minute examination—and then left the room and the nurse came in.

Q.—Then what occurred? *A.*—She had been given morphine, just how, I do not know; and she was under it and, in fact, she became unconscious, went out of her head. In forty minutes the nurse came in and stayed there a few minutes. I left the room and went down to the desk and inquired at the information desk, the switchboard operator, inquired as to where I could locate Dr. Selders. She said he was in the operating room. She handed me a phone and some one got Dr. Selders on the wire. He said, "We are in the operating room." I said, "I would like to talk to you." He said, "Come down if you wish. I will meet you."

Q.—Did you go? *A.*—Yes, but unfortunately they were in the operating room, both dressed for operation.

Q.—Did you go in the operating room? *A.*—Yes, but I had to come out immediately.

Q.—Who was in the operating room? *A.*—Dr. Dugan and Dr. Selders, both dressed for an operation. One was scrubbed for an operation.

Q.—What was said in that room? *A.*—I asked why they were prolonging the operation. Dr. Selders said he was not permitted to operate because he was a member of the staff of Group Health, and Dr. Dugan said, after examining this case, he didn't find it acute; and Dr. Selders repeated this statement, "He refuses to let me operate until he gets authority." I said "this is no time to argue whether it is acute or not acute. Dr. Selders has examined her and has pronounced it acute; and I wish something could be done about it." They walked to an ante room and discussed the pros and cons of some medical book that meant nothing to me; I couldn't understand it. In the meantime, let's see; I think Dr. Selders spoke to me. He said, "There is nothing I can do." I said, "Isn't this acute?" And he said, "Yes, it is definitely so."

Q.—Did Dr. Dugan suggest to you that some other doctor perform the operation? *A.*—Well, I left the operating room and went upstairs and Dr. Selders followed behind, with Dr. Dugan. While Dr. Dugan was coming, I said, "It isn't necessary for you to come along." I was infuriated by this time. I went to Miss Tew's room and I told Mr. Adams they were not going to allow Dr. Selders to operate. Dr. Dugan walked in and said he would like to talk with Miss Tew. In fact, he would like to offer the services of someone on their staff. At that time she was just coming out of a stupor there. She didn't know what she was doing. He wanted her to sign a release. I refused to let her sign the release. She said, "Must I sign this in order to leave?" He said, "No, it isn't necessary." With that he left the room. We waited outside approximately twenty minutes and she went back into a sleep and the nurse came in with an ice pack about twenty minutes afterward. I turned to ask them then if I could get an ambulance and I think the nurse, she said, "Yes, it will cost a fee of three dollars." I used the telephone. I said, "If you won't call a cab, may I call a cab?" which I did.

Q.—Did Dr. Dugan come into the room a second time? *A.*—After reading the release?

Q.—Yes. *A.*—That I cannot recall. There was so much commotion going on, I can't recall; so the cab arrived. I dressed Miss Tew; I didn't get any help. Mr. Adams stayed outside. I think he asked for a wheel chair; at least one was brought. They put her in it and wheeled her out to the main entrance and at the entrance she fainted on the steps.

Q.—How long was she on the steps? *A.*—Fifteen or twenty minutes, I would say, and she wasn't conscious until we got her to the apartment, and we practically carried her, Mr. Adams and myself, put an ice pack on her, and put her to bed.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Were you rooming with her at this time? *A.*—Yes.

Q.—How long had you been living with Miss Tew? *A.*—Let's see, approximately two years, I think.

Q.—Did you work in the same office together? *A.*—No, we did not.

Q.—Had you known Miss Tew a long time? *A.*—About six years.

Q.—What office were you employed in? *A.*—The Federal Works Agency.

Q.—And where was she employed? *A.*—In the Home Owners' Loan.

Q.—How long had you known Mr. Adams? *A.*—Four or five years.

Q.—Mr. Adams and you were good friends? *A.*—Very good.

Q.—Were you both going together at the time? *A.*—We were.

Q.—Who was it called Mr. Adams that night? *A.*—You mean the night Miss Tew went to the hospital?

Q.—Yes. *A.*—I think I did; I am not sure.

Q.—Miss Tew had been sick there for about a week? *A.*—Four or five days.

Q.—And some one of the doctors had diagnosed the case as appendicitis, when you first called the doctor in? *A.*—Yes, it was the Group Health medical doctor.

Q.—A week before that time he had pronounced it appendicitis? *A.*—I wouldn't say so definitely, that he did; I don't recall—this has been two or three years ago; my mind isn't very clear on it.

Q.—But you do know a Group Health doctor was called in to see Miss Tew? *A.*—Yes.

Q.—And he diagnosed her condition as requiring an operation? *A.*—Yes.

Q.—And for that reason you called Dr. Selders? *A.*—He called him, I didn't.

Q.—In any event, Dr. Selders left her in the apartment for approximately a week in that condition? *A.*—Four days. He saw her every day. The reason nothing was done was that he didn't have a hospital at that time to take her to. As soon as he was able to take her to Garfield he did.

Q.—Did he leave her in the apartment from the 19th of February until the 26th of February? *A.*—If that is the date she went to the hospital, yes.

Q.—And you told us yourself, regardless of the date, that she was sick for about a week? *A.*—Yes.

Q.—And you told us you were feeding her soups and broth for about a week? *A.*—Yes.

Q.—So it was upon your advice or Dr. Selders' that you thought you would move her to the hospital on the night of the 26th? *A.*—Dr. Selders'. She became quite ill that evening, at about 6 p. m.—6 or 7 p. m.

Q.—Did you make any arrangements at Garfield yourself? *A.*—I had no connection with the hospital, no.

Q.—Were you present when the arrangements were made with Garfield? *A.*—That is right. The doctor came in the apartment and said he had made the arrangements, but he would call me back and let me know definitely; I wasn't present when he talked with them.

Q.—So it was Dr. Selders that told you to take her to the hospital? *A.*—Yes.

Q.—And that was when you called Mr. Adams? *A.*—I believe he was there. I am not sure; he lived in the same building. I couldn't tell you whether he was in the apartment at the time or not.

Q.—And you assumed when Dr. Selders told you that he had made arrangements with Garfield that he had done so? *A.*—Yes

Q.—Did he tell you that arrangements were made to put her in a room, or for him to operate on her? *A.*—I don't recall, other than I know when we went to the hospital, he told me to present the Group Health card at the desk. It was accepted and a room assigned.

Q.—Did you present any other card besides the Group Health card? *A.*—It seems to me like I did, but I am not sure.

Q.—But in any event no question was raised and the young lady was assigned to a room? *A.*—Yes.

Q.—The only question which arose there that evening was whether Dr. Selders had the privilege of the Courtesy Staff to operate there? *A.*—Yes.

Q.—And, of course, you naturally assumed he had such privilege? *A.*—Yes.

Q.—You wouldn't have gone there if you didn't so think? *A.*—No, sir.

Q.—And you wouldn't have advised your friend, if you knew Dr. Selders did not have such privilege to be operated on that hospital by him? *A.*—I wouldn't advise any one that way, would you?

Mr. Leahy:—You bet I wouldn't!

By Mr. Leahy:

Q.—Now, there came a time when it was found that Dr. Selders wanted to operate and Dr. Dugan raised the question he was not on the staff, the courtesy staff. *A.*—Yes.

Q.—And Miss Tew took the position that if Dr. Selders couldn't operate she would leave the hospital? *A.*—She didn't; I took it for her.

Q.—And you told them in no uncertain manner that unless Dr. Selders was permitted to operate on Miss Tew there at that hospital she would leave? *A.*—Yes.

Q.—And didn't Dr. Dugan advise against that? *A.*—No.

Q.—Didn't he say that it was not a good thing for her to leave the hospital? *A.*—Not to my recollection.

Q.—Do you recall having a release presented for Miss Tew to sign? *A.*—He read it at the foot of her bed; that is the release I am talking about.

Q.—Did you look at it? *A.*—I didn't; he read it. I don't think this is the correct form he read.

Q.—Won't you read it over carefully and see if it won't refresh your memory? *A.*—I don't remember this.

Q.—You do remember some kind of a paper presented to Miss Tew? *A.*—Yes.

Q.—And you advised against her signing it? *A.*—Yes.

Q.—And, of course, you read it before that? *A.*—No, I didn't.

Q.—Well, you heard it read. *A.*—She said, "Must I sign this to leave the hospital?" And I said, "She is not going to sign it."

Q.—Did she read it? *A.*—Apparently this is what she read, but I can't say; I didn't read it.

Q.—Don't you remember that he read the statement there to Miss Tew? *A.*—I am sorry; I can't admit it because I can't remember whether or not that is it.

Q.—Didn't he read, "I hereby acknowledge"—

Mr. Kelleher:—It is not in evidence.

By My Leahy:

Q.—I will ask you again if Dr. Dugan at that time didn't say—

Mr. Lewin:—We object to it. It is just repetition. He has already asked that question.

THE COURT:—Yes.

Mr. Leahy:—I would just like to ask the direct question: Didn't Dr. Dugan say that Miss Elizabeth Tew was leaving against the advice of the attending physician? *A.*—I don't recall Dr. Dugan saying that.

Q.—But at all events you told Miss Tew not to sign this release? *A.*—Yes.

Q.—Do you know what time that was? *A.*—Let's see. We went in there; she was in the room 40 minutes before she got any attention whatsoever; I was downstairs 20 minutes; that is an hour, and it was midnight when we got home.

Q.—Do you recall it was about 9:55 p. m. when all this occurred in the room? *A.*—Well, judging from the space we covered it could be, but I couldn't say.

Q.—How long after 9:55, if that was the time, did you remain in the hospital before you left? *A.*—Approximately an hour; an hour and fifteen minutes.

Q.—What time did you get home? *A.*—Close to midnight.

Q.—How long did it take to go by cab from Garfield to California Street? *A.*—I imagine about ten minutes.

Q.—Then it was approximately 11:30 p. m. when you started to leave Garfield? *A.*—I won't say definitely.

Q.—Did you call the cab from Garfield? *A.*—Yes.

Q.—Was the cab there before you started to leave Garfield? *A.*—The cab was waiting. He had to wait for her to come there.

Q.—She had fainted? *A.*—Yes.

Q.—Did she fall down when she fainted? *A.*—I think between Mr. Adams and I she fell; she slumped; we will put it that way.

Q.—Did you both sit on the steps there to hold her? *A.*—Yes.

Q.—You sat there, you on one side and Mr. Adams on the other? *A.*—I know she slumped on the steps of the hospital. We waited until she was ready to leave.

Q.—How long do you think you were there? *A.*—It seemed endless, but I would say ten or fifteen minutes.

Q.—Did Dr. Dugan there that evening twice offer to Miss Tew the services of any one on the staff of Garfield? *A.*—I don't recall whether he was in twice to render this service or not. I do recall mentioning several surgeons on the staff, and saying how competent they were, and asking for her selection; whether he appeared twice with that in mind I couldn't say.

Q.—But at that time you said "no"; if she couldn't have Dr. Selders she would leave the hospital? *A.*—That is right.

Mr. Leahy:—I think that is all.

Mr. Lewin:—There is one point that we might clear up as a basis for arguing this other matter. Let me ask if the witness is here.

Mr. Kelleher:—In the meantime, I offer in evidence Exhibit 584, which is the release.

THE COURT:—Any objection?

Mr. Leahy:—No.

THE COURT:—Admitted.

Mr. Kelleher:—I won't read the full release but I would like to show this. On the bottom of the release, which has been read by Mr. Leahy, appears the handwriting, the handwritten memorandum "Patient refused to sign release slip at 9:55 p. m.," and in the margin also "Present but not signing"—

TESTIMONY OF ANNA MARY DENNINGER

The witness again identified Dr. Mann's signature on a document.

EXHIBIT U. S. 583

"SIBLEY MEMORIAL HOSPITAL
"1130 North Capitol Street,
"Washington, D. C.
"November 27, 1937.

"Dear Doctor:

"Dr. Raymond Everett Selders has requested the privilege of treating the following in Sibley Memorial Hospital:

"Medicine
"Minor and Major Surgical
"Normal and Abnormal Obstetrics
"Minor Gynecology
"Major Gynecology

"As a member of the Advisory Committee on Surgery will you kindly indicate your approval or disapproval at the bottom of this letter and return it to the office of the President of the Hospital before Tuesday.

"Very sincerely yours
"PAUL S. PUTZKI, M.D., Chairman.

"Applicant's credentials on file in the office of the President.

"Attention of the Committee is called to the fact that above applicant is one of the salaried physicians of the Home Owners Loan Corporation Group Health Association and that information as to his qualifications and correspondence in connection with his application will be found on file in the President's office available to members of the various committees concerned for their information.

"Not approved. "J. T. MANN."

MARCH 4—MORNING

TESTIMONY OF WILLIAM F. PENNIMAN

FURTHER DIRECT EXAMINATION

By Mr. Kelleher:

Q.—Mr. Penniman, do you know to what hospital Miss Elizabeth Tew was taken? *A.*—Garfield.

Q.—Did you have a talk with Mr. Eisenman on Nov. 27, 1938? *A.*—I had a talk with Mr. Eisenman, I think about that date; the latter part of November.

Q.—Who is Dr. Eisenman? *A.*—Superintendent of Garfield.

Q.—What was the conversation you had with him? *A.*—It was quite lengthy; we went into a good deal of discussion about Group Health, et cetera.

Mr. Leahy:—May this be considered under the same objection?

The Witness (continuing):—And he told me the most important thing was that no hospital had the right to refuse admission to a patient in an emergency case and that no hospital had the right to refuse that patient the right to bring their own doctor, if it was an emergency, so long as such doctor was duly and properly licensed to practice medicine in the District of Columbia. Following that he told me that I could tell Dr. Brown, Medical Director, that in those cases which were emergency he could send such cases to Garfield and that Dr. Selders, who was regularly licensed to practice medicine in the District of Columbia, could attend them.

Q.—Was that permission ever formally revoked? *A.*—Yes; it was subsequently.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Do you recall when that permission was revoked? *A.*—I don't remember exactly the date; I remember there was a letter written to him in which it was stated that until the legality of Group Health was determined he would not have any privileges in the hospital.

Q.—Didn't that letter refer to ordinary courtesy privileges? *A.*—I don't recall that.

Q.—Was there any other revocation of the emergency privilege than the letter you just referred to, which you can now recall? *A.*—No, I think it was accepted as a revocation of the privileges that he had had.

Q.—That is the only revocation that you can recall—that letter? *A.*—Yes.

Q.—And that was dated Jan. 25, 1938? *A.*—That I couldn't recall; I don't remember the date.

Q.—Now, who accepted that? Did Dr. Selders accept that as a revocation of his privileges to bring into Garfield even an emergency case? *A.*—I assume he did; he didn't go back.

TESTIMONY OF CLARK PAUL HALSTEAD

DIRECT EXAMINATION

By Mr. Kelleher:

Dr. Clark Halstead said he is employed by Group Health Association.

Q.—When did you join Group Health Association? *A.*—August 1938.

Q.—Where did you attend for your education? *A.*—I did my premedical work at George Washington, transferred to Georgetown University; interned at Georgetown University Hospital.

Q.—When did you finish your internship there? *A.*—June 30, 1938.

Q.—After you joined Group Health Association did you apply to any of the local hospitals for courtesy privileges? *A.*—I did.

Q.—To what hospitals did you apply? *A.*—I applied to Georgetown Hospital, Garfield, Providence, Emergency Hospital and George Washington Hospital.

Q.—Did you apply to Sibley Hospital? *A.*—I did, I believe.

Q.—And when did you apply to these hospitals? *A.*—August 1939, with the exception of Garfield, which was October 1938.

Q.—And for what privileges did you apply? *A.*—General medicine and minor surgery.

Q.—What is minor surgery? *A.*—It is considered any type of minor operation. It is a rather broad term but excludes abdominal surgery or other major types of surgery and, of course, it would include many things; the general practitioner with certain experience is entitled to do certain types of minor surgery.

Q.—Would you say minor surgery embraces that surgery which any general practitioner is considered qualified to do? *A.*—Yes.

Q.—Prior to Dec. 20, 1938 did you receive word that your application for courtesy privileges had been granted? *A.*—No action was taken on any of them except, I believe, I was notified from Emergency Hospital that I was not admitted, but I don't recall the date.

Q.—Was it prior to Dec. 20, 1938? *A.*—I don't think so.

Q.—No action at all prior to that date? *A.*—No action at all.

CROSS EXAMINATION

By Dr. Leahy:

Q.—Doctor, when did you say you finished your intern training? *A.*—I believe it was June 30, 1938; the end of the fiscal year for internship ends on the 1st of July.

Q.—And then you immediately applied for the position with Group Health? *A.*—I did not; I didn't make any application; I made no application. I was approached by them.

Q.—Who was it that approached you? *A.*—Dr. Selders.

Q.—In August 1938? *A.*—I believe it was before that; I was intern at Georgetown Hospital. I didn't make any application. As I say, I handled a case in my service as intern in Georgetown, which was a fracture case, and later I was contacted by Dr. Selders, before I completed my internship.

Q.—You really began your employment with G. H. A. on what date? *A.*—August 1.

Q.—Did you personally make application to the hospitals? *A.*—Yes, through letter.

. . . . . .

Q.—You didn't save any copies of those? *A.*—Unfortunately, I did not; they should be in the hospital records.

Q.—Did anybody for G. H. A. make any application for you to your knowledge at any of these hospitals? *A.*—I don't know what you mean.

Q.—Did Mr. Kirkpatrick make any application for you? *A.*—Certainly not; these applications were signed by myself.

Q.—But you do not know where the copies of those may be? *A.*—No, I do not.

Mr. Allen:—I wish to read Exhibit 72, a letter dated Oct. 30, 1937, from Dr. Conklin to Dr. Holman Taylor, Secretary, State Medical Association of Texas:

U. S. EXHIBIT 72

"Dear Dr. Taylor:

"I was very happy to hear from you and particularly glad to learn of your successful operations. It is indeed odd to have kidney stones without knowing it, but their removal, I am sure, will mean real satisfaction and the elimination of potential danger.

"The Group Health Association is progressing. October 30, tonight, there is a banquet at the Mayflower Hotel which will be addressed by Richard Cabot of Harvard University. Most all of the hospital superintendents have been invited to attend, some of whom, I believe, will fail to be represented at the gathering. Our president received a letter of invitation, also a ticket. Needless to say this will represent another vacant chair. The staff is made up, according to information at hand, of 5 doctors, in one of whom you may have an interest, due to the fact that the American Medical Directory states that he is a member of the State Medical Society of Texas. Raymond Everett Selders appears to have been born in 1892; graduated at the University of Oklahoma, 1927, etc., etc. He, I believe, will assume the surgical responsibilities.

"The clinic is located on the second floor of a building in the downtown section. The first floor is occupied by an electric light appliance concern. Reports show that they have received some financial assistance from the Federal Home Loan Bank Board. The setup, without the shadow of a doubt, seems to have the smiling approval of the various New Deal officials and the Secretary of Labor, on through.

"I am hoping that the residual soreness as a result of your operation will have completely vanished by the middle of November so that we all may have the advantage of your presence and counsel at the American Medical Association meeting of State Secretaries.

"With cordial regards, I am,

"Fraternally yours,
C. B. Conklin, M.D.,
Secretary."

The next is Exhibit 73-A, dated Nov. 4, 1937, written by Dr. Holman Taylor to Dr. C. B. Conklin, Secretary, Medical Society of the District of Columbia:

U. S. EXHIBIT 73-A

"Dear Dr. Conklin:

"I thank you for your favor of October 30, in reply to my letter of October 27, and having to do with the health insurance situation in the District of Columbia, just received.

"I note with interest that a member of the Harris County (Texas) Medical Society is a member of the staff of the institution which is to be set up in Washington as a beginner in 'State Medicine'; that, in fact, he will take charge of the surgery in the new set-up, Dr. Raymond Everett Selders.

"Please let me know just as soon as the situation has developed in the District of Columbia to such an extent that charges of unethical conduct may be successfully lodged against Dr. Selders. I will see that the facts in the case are laid before his society. I don't believe the members of that organization will stand for anything of this sort, but even so, they are very fair down there, and rather discriminating. They tend to their knitting like few other organizations of the sort with which I am acquainted. If we will give them the facts, they will do the buck; without the facts they will hardly do anything about it.

"I note your statement that the Group Health Association about which we have been writing, is about ready to go. Again I give it as my opinion that this organization has been inspired by some who are in high authority in our national government.

"With personal regards,

"Fraternally yours,
"Holman Taylor,
Secretary."

The next exhibit, 538, is a letter dated Nov. 25, 1937, on the letterhead of the Columbia Hospital for Women, Washington, D. C., signed by P. M. Ashburn, M.C., Secretary of the Medical Board, addressed to the Secretary, Houston Medical Society, Houston, Texas:

U. S. EXHIBIT 538

"Sir:

"I am directed by the Medical Board of this hospital to seek your aid in determining the qualifications of Dr. Raymond E. Selders, who practiced in Houston from 1928 to 1935, for doing major and gynecological surgery and operative obstetrics.

"Dr. Selders is an employee of a medical cooperative or insurance organization recently formed by employees of the Home Owners Loan Corporation. This movement has received national attention and has excited much opposition in local medical circles. Dr. Selders, while apparently a generally well trained man, has not submitted evidence of the special training and experience usually demanded by this hospital of men seeking the privilege of doing operative work in gynecology and obstetrics.

"Because of the special circumstances of the particular case and the Board's desire to act in a fair and judicial manner, any assistance you can give it will be greatly appreciated and will be held confidential."

And the next is Exhibit 539, dated Dec. 2, 1937, a reply to Dr. Walter A. Coole, to Dr. Ashburn, Secretary, Medical Board, Columbia Hospital for Women:

U. S. EXHIBIT 539

"Dear Doctor Ashburn:

"Your letter of November 25 regarding the qualifications of Dr. Raymond E. Selders has been referred to me for answer.

"Dr. Selders is a member of this Society in good financial standing. His record here is clear and shows that he is academically and professionally well qualified. I have been given to understand that recently he completed his Masters Degree in Surgery at the University of Pennsylvania which should further qualify him.

"We have been recently informed that he is an employee of the Home Owners Loan Corporation in a contract medical capacity and our Board of Censors are at present investigating the source of this information.

"The Harris County Medical Society strongly condemns any such practice and if the allegations are found to be true, Dr. Selders will be subject to disciplinary action on the part of the Society.

"Further than this, I have no information."

The next is Exhibit 81, dated Jan. 14, 1938, on the letterhead of the Harris County Medical Society, signed by A. T. Talley, Chairman, Board of Censors, Harris County Medical Society, addressed to the Secretary, Medical Association of D. C.:

U. S. EXHIBIT 81

"Dear Doctor:

"The Harris County Medical Society, a component of the State Medical Association of Texas and the American Medical Association, is very anxious to know the medical status of the so-called Group Health Asso-

V 19

ciation, located there in Washington. We are especially anxious to know the ethical standing of the men who compose its staff as one of the staff members belongs to our local Society.

"Any information you are in position to give us will be appreciated."

At the bottom, and on the back in pencil is a letter which has been identified as having been written by Dr. Conklin. It is identical with Exhibit 80, which I will read.

Mr. Lewin:—It is a rough copy?

Mr. Allen:—Rough, in handwriting.

Exhibit 80 is dated Jan. 19, 1938 and is a letter from Dr. Conklin, Secretary, to Dr. A. T. Talley, Chairman, Board of Censors, Harris County Medical Society:

U. S. EXHIBIT 80

"In re: H. O. L. C., Group Health Association

"Dear Doctor Talley:

"In reply to your letter of Jan. 14, 1938 I would state that two members of this Society accepted employment; one at $2,400 to take all calls, another at $4,800. The latter resigned from H. O. L. C. after his 'trial' before an appropriate committee of the Society for violation of provisions of the Society's Constitution lasted one night. The other continued; his hearing is now completed. It would seem that he will lose his membership. It must be noted that much praise was given him by the full-time governmental attorneys who represented him.

"I am enclosing certain available mimeographed information. Should you wish any further data please communicate with me."

The next is Exhibit 540, a letter dated Jan. 31, 1938 on the letterhead of the Harris County Medical Society, from A. T. Talley, Chairman, Board of Censors, Harris County Medical Society, addressed to Dr. Raymond E. Selders, 2445 Fifteenth Street N.W., Washington, D.C.:

U. S. EXHIBIT 540

"Dear Doctor:

"At a business meeting of the Harris County Medical Society, Jan. 26, 1938, the Board of Censors reported that it had received a communication from the Secretary of the District of Columbia Society through Dr. Holman Taylor, Secretary of the State Medical Association of Texas at Fort Worth, that a member of the Harris County Medical Society had accepted a position on the Surgical Staff of the so-called Group Health Association made up of Federal employees of the H. O. L. C., located in Washington, D. C. (No name was mentioned.) The Board of Censors stated from their interpretation of the Code of Ethics of the American Medical Association, under which we practice, that it was unethical for one of our members to accept a position of this kind. This interpretation was upheld by a unanimous vote of the Society.

"Hoping you will continue to be with us and that we may hear from you immediately, I am,

"Sincerely,"

The next is 541, dated Feb. 10, 1938 from Dr. Raymond E. Selders to Dr. A. T. Talley, Chairman, Board of Censors, Harris County Medical Society, Houston, Texas. The entire letter has not been admitted in evidence; only one paragraph.

U. S. EXHIBIT 541

"It will be greatly appreciated if I may have from you a frank statement of the grounds on which the action which your letter discloses were taken. It seems to me that I am entitled, under the circumstances, to a full expression of the views of the membership which brought forth what you have described as a unanimous vote of the Society."

Mr. Allen:—The next is Exhibit 545, dated April 15, 1938, from Dr. Walter A. Coole to Dr. Raymond E. Selders, Group Health Association, Washington, D. C. In lieu of reading that exhibit which I mentioned, I wish to read an excerpt from the minutes of the Harris County Medical Society dated Jan. 26, 1938. That is Exhibit 556. I should also like to state that the minutes are only offered and not the attachments thereto, some of which are marked separately.

This is the report of "Boards and Committees":

U. S. EXHIBIT 556

"Dr. A. T. Talley, Chairman of the Board of Censors, reported upon an appeal from a decree of the Adjudication Committee, the approval of two new members for membership, and the matter of one of our members affiliating with a contract organization in Washington, D. C. Motion made, seconded and carried that this report be accepted. Report attached."

Mr. Allen:—Now, I wish to read an excerpt from Exhibit 558, which is the regular business meeting of the Harris County Medical Society, dated March 30, 1938:

U. S. EXHIBIT 558

"Dr. A. T. Talley, reporting for the Board of Censors, preferred formal charges of unethical practice against Dr. Raymond E. Selders. These charges are attached hereto and made a part of these minutes."

Now, we will read Exhibit 545, a letter dated April 15, 1938, from Dr. Coole to Dr. Selders.

U. S. EXHIBIT 545

"Dear Doctor Selders:

"This is to inform you that formal charges, copy of which were sent to you, were read by the Board of Censors at the last regular Business Meeting of the Harris County Medical Society, March 30, 1938.

"These charges shall be submitted to the Society in executive session at the next Regular Business meeting, April 27, 1938, for action by the Society.

"In accordance with the By Laws and Constitution of the Society, you may conduct your own defense, or select some other member to conduct it for you. If you should be absent, or fail to appoint some member, the president shall appoint a member to defend you.

"I am in receipt of your answer to these charges and shall turn them over to the member appointed to defend you should you be absent.

"Sincerely yours,
"Walter A. Coole, M.D.,
"Secretary."

Mr. Allen:—I will read Exhibit 543-A, a letter dated March 9, 1938, signed by three members of the Board of Censors. It reads:

U. S. EXHIBIT 543-A

"Mr. President and Members,
Harris County Medical Society.

"The Board of Censors of your Society does hereby formally prefer charges of unethical practice against one of your members, Dr. Raymond E. Selders.

"This incident charges him with accepting a position on the surgical staff of a group health association, made up of Federal employees of the Home Owners Loan Corporation, located in Washington, D. C. This type of practice is unethical as judged by Article VI, Section 3 of the American Medical Association's Code of Ethics, in that:

"(1) The compensation is inadequate to assure good medical service.

"(2) It interferes with reasonable competition among the doctors in the city of Washington, D. C.

"(3) It interferes with the free choice of a physician by the patient.

"(4) It is contrary to sound public policy.

"Respectfully submitted:
"A. T. Talley, M.D., Chairman.
"John H. Foster, M.D.
"C. M. Warner, M.D."

The next I will read is Exhibit 560, Minutes of the Harris County Medical Society, Regular Business Meeting, April 27, 1938:

U. S. EXHIBIT 560

"The President announced an executive session. Assembly Hall was cleared at 8:30 p. m.

"Dr. J. C. Alexander was appointed by the President to act as defender to formal charges filed against Dr. Raymond E. Selders.

"The formal charges as set forth in the minutes of the Business Meeting of March 30, were read by the Secretary.

"The President asked the Defense, 'What is your answer—Guilty or Not Guilty?'

"Dr. J. C. Alexander:—Not Guilty. Is Dr. Selders a member in good standing of this Society?

"Secretary:—Dr. Selders is on the rolls of the Society as a suspended member, his dues having expired April 1st.

"Dr. J. C. Alexander:—I will make the motion that these charges be deferred inasmuch as Dr. Selders is not a member in good standing.

"Dr. William E. Ramsay:—We have no other option, other than to proceed with this trial.

"Dr. A. T. Talley:—There is no question about the status of Dr. Selders. As a suspended member on the rolls of the Society, he is under the discipline of the Society; however, I wish to offer this resolution:

"'Dr. Raymond E. Selders, a member of our Society, was indicted by the Board of Censors for unethical practice upon a complaint from the District of Columbia Society, through Dr. Holman Taylor, Secretary of the State Medical Association of Texas, that he had accepted a position on the surgical staff to do contract practice for a Group Health Association, made up of Federal employees of the H. O. L. C. in Washington, D. C.

"'Since reading the indictment to the Society at the March Business Meeting, the Board of Censors has had an opportunity to study the By-Laws of the American Medical Association in reference to this matter and we find in Chapter IX, Section 1, pertaining to duties of standing committees and councils, words which according to our interpretation mean that in any controversy between a constituent association and a member or members or another constituent association, the Judicial Council has original jurisdiction in adjudicating the controversy. Therefore, according to this By-Law, the controversy between the District of Columbia and Dr. Selders, who is a member of the State Medical Association of Texas, both constituent associations, should be referred by this Society directly to the Judicial Council of the American Medical Association for adjudication.

"'The Board of Censors moves that this be done.'

"Dr. J. C. Alexander:—Will the Chairman of the Board of Censors quote this authority?"

I will not read it; it is quoted.

"The President called for a vote upon the motion of the Board of Censors. The motion carried by a vote of 41 in favor of the motion and 4 against it."

And without reading the minutes, if it is agreeable to counsel, may it be understood that it was referred to the American Medical Association and was returned by the American Medical Association to the Harris County Medical Society?

Mr. Leahy:—Yes; sure.

Mr. Allen:—Next I will read the Minutes of the Special Business Meeting, Nov. 23, 1938, of the Harris County Medical Society, Exhibit 563:

U. S. EXHIBIT 563

"Meeting called to order by Dr. John T. Moore, President.

"Dr. A. T. Talley presented the following resolution of the Board of Censors:

"'The Board of Censors, Drs. A. T. Talley, John H. Foster, and Clyde M. Warner, met with your President, Dr. John T. Moore, the Secretary, Dr. Walter A. Coole, the District Counselor, Dr. Judson L. Taylor, and the legal representative of Dr. Raymond E. Selders, Dr. J. C. Alexander, Nov. 21, 1938.'

"The meeting was called to order and a very free and frank discussion was held regarding the Dr. Raymond E. Selders matter, which has been pending in our Society for some time.

"'The conclusion reached by the Board of Censors was agreed to by all those present, that due to the various legal questions involved in the case, the Board of Censors recommends to the Society:

"'That the charges of unethical practice against Raymond E. Selders, now lying on the table, be brought before the Society and dismissed without prejudice.'

"Motion was made by Dr. John Zell Gaston, seconded by Dr. William E. Priester, and duly carried, that the resolution of the Board of Censors be adopted.

"Dr. Talley presented the following resolution of the Board of Censors:

"'That the check of $24 tendered the Society by Dr. Raymond E. Selders to pay his 1938 dues be accepted.'

"Motion was made by Dr. B. T. Van Zant, seconded by Dr. Dawes, and carried, that the resolution of the Board of Censors be adopted.

"Letter of transfer from the Harris County Medical Society was read by the Secretary from Dr. Raymond E. Selders.

"Motion by Dr. A. T. Talley, seconded by Dr. Priester, that the letter of transfer be voted upon at the next regular business meeting, Nov. 30, 1938. Motion carried."

The next is Exhibit 564, dated Nov. 30, 1938, "Unfinished Business," regular business meeting, Harris County Medical Society:

U. S. EXHIBIT 564

"'Voting on the application of Dr. Raymond E. Selders for transfer. Vote by ballot 52 yes, 42 no that Dr. Selders be granted a transfer.'"

Mr. Lewin:—I now offer in evidence Exhibit marked 585, which purports to be a letter from Dr. Thomas E. Neill, President, District Medical Society, to the Superintendent of the Homeopathic Hospital, dated April 23, 1938. I call attention of the Court that Dr. Neill's signature has already been proved by specimens which are in evidence, and I will ask the Court to exercise its discretion in comparing the signatures. The letter was obtained by us and produced from the Homeopathic Hospital, from its files.

Mr. Leahy:—No special objection.

THE COURT:—It will be admitted.

Mr. Lewin:—May I characterize it without reading it? It is simply an invitation by President Neill to the hospitals to attend a meeting in April of 1938. There has been other testimony with regard to it.

Mr. Richardson:—State the purpose of it.

Mr. Lewin:—I better read it then.

U. S. EXHIBIT 585

"Dear Mrs. Treasure:

"The Executive Committee of the Medical Society of the District of Columbia believes that a joint meeting of the Presidents of the Boards of Directors of the several hospitals, together with their Chairman of the Medical Staffs, and Superintendents, and a few members of the Medical Society, for a round table discussion of our common problems, may result in a fuller and better understanding, especially in preserving the best professional care for our community.

"You are, therefore, cordially invited to be present on Tuesday, April 26, 1938, at 8 p. m., in the Library of the Medical Society Building, 1718 M Street, N. W. This meeting is entirely for our mutual understanding and not for publication.

"Very sincerely yours,
"Thomas E. Neill, M.D.,
"President."

TESTIMONY OF GRACE BRENNEN

DIRECT EXAMINATION

By Mr. Lewin:

Grace Brennen said she is secretary of Dr. Jerome Crowley.

Q.—I show you an exhibit marked 307, which purports to be some questions and answers—the questions in typewriting and the answers in longhand, and I call your attention to the answers to question 8, and question 11, and ask you whose writing that is in. *A.*—Dr. Crowley's.

Q.—Is the rest of the handwriting Dr. Crowley's? *A.*—No, unless he used a very bad pen.

TESTIMONY OF JOHN PAUL FOLEY

DIRECT EXAMINATION

John Paul Foley said he is Assistant Secretary of the Commission on Licensure.

Q.—Just what is that commission? *A.*—That commission is a body of men created by an Act of Congress to regulate the healing art practice in the District of Columbia.

He produced the original application of Thomas E. Mattingly for licensure.

Mr. Leahy:—Objection is raised, if your Honor pleases, to Exhibit 587.

By Mr. Leahy:

Q.—Is it Mr. Foley or Dr. Foley? *A.*—Mr. Foley.

Q.—Mr. Foley, when did you go to work for the Board of Licensure? *A.*—1935.

Q.—Then all you know about this particular document, which has been identified as 586, is that in accordance with the mandate of this subpoena you withdrew this from the records of your office and produced it? *A.*—Yes.

Mr. Leahy:—Objection to 586.

Mr. Lewin:—Exhibit 586 is one of the formal original records of this public body, the Commission of Licensure.

By Mr. Lewin:

Q.—That is true, is it not, Mr. Foley? *A.*—Yes.

Mr. Lewin:—No further questions. We submit it to your Honor. (Thereupon, Court and counsel conferred at the bench.)

TESTIMONY OF HARRIET AUSTIN

DIRECT EXAMINATION

By Mr. Lewin:

Harriet A. Austin lives in Chevy Chase, Maryland. In September 1938 she lived in Foxhall Village.

Q.—Were you entitled to privileges then in Group Health Association? *A.*—Well, not until after this accident.

Q.—Did you say you had an accident: When did you have that? *A.*—I can't remember. That accident spoiled my memory.

Q.—It spoiled your memory? Would you say it was in September of 1938? *A.*—I guess about that.

Q.—Can you remember where it happened? *A.*—Well, it was down on Pennsylvania Avenue. The street car was waiting there and it took me a half hour to get home, and I was in a hurry—

Mr. Leahy:—If the accident occurred before she became entitled to G. H. A. service, it is immaterial.

By Mr. Lewin:

Q.—At that time you had a daughter, didn't you, Mrs. Austin? *A.*—Yes.

Q.—What was her name? *A.*—Edwina Avery.

Q.—Was she a member of Group Health Association? *A.*—Yes.

Q.—And were you dependent upon her? *A.*—Yes.

Q.—At the time of the accident, that is true, isn't it? *A.*—Yes.

Q.—So that at the time of the accident, although you were not a member yourself of Group Health Association, you were a dependent of a member: that is right? *A.*—Yes.

Q.—Now, when you were interrupted you were telling us about an accident. Will you continue to do so? *A.*—I started over toward the street car, and the car came down the hill, and turned right around quick—

THE COURT:—We don't want to go into the details. She was injured?

Mr. Lewin:—His Honor doesn't want to hear anything more about that.

By Mr. Lewin:

Q.—What happened after you were struck by the car? *A.*—I didn't know for a while; they got me to the hospital.

Q.—What hospital did they take you to? *A.*—Emergency Hospital.

Q.—Here in Washington? *A.*—Yes.

Q.—What happened when you got to the hospital? *A.*—They first put me in a bed and took my clothes off, and examined me.

Q.—Who examined you, a young doctor there? *A.*—I don't know. I didn't know very much about it.

Q.—Did they give you any treatment? *A.*—No.

Q.—They did not? *A.*—Did not.

Q.—And did you ask for anybody? *A.*—I told them I would like to send word to my daughter.

Q.—That is Mrs. Avery? *A.*—Yes.

Q.—And did your daughter come there? *A.*—She and her husband came right down.

Q.—What happened after that? Were you taken from the hospital then? *A.*—Yes.

V 19

Q.—Shortly after they came? *A.*—Yes, not very long after.
Q.—And were you taken away in an ambulance? *A.*—In an ambulance, yes, Hines Company ambulance.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Do you remember the year? *A.*—I don't know whether I could do that; my memory was destroyed at that time.
Q.—Do you remember the name of anybody at the hospital? *A.*—At the Emergency?
Q.—Yes. *A.*—No, I had never been there before.
Q.—Do you know whether they took you in a room? *A.*—Yes, they put me in almost a corridor; curtains around it.
Q.—Did they examine you? *A.*—There was one person, they told me afterwards; I didn't know very much about it, anyway.
Q.—You didn't know much what happened, did you? *A.*—No.

TESTIMONY OF EDWINA AVERY

DIRECT EXAMINATION

By Mr. Kelleher:

Edwina Austin Avery said she is Mrs. Austin's daughter. She was an employee of the Department of Agriculture in 1938.
Q.—Were you also a member of Group Health? *A.*—Yes.
Q.—Under your membership, was your mother entitled to benefit from that organization? *A.*—That is right.
Q.—And was this true in September 1938? *A.*—That is right.
Q.—On Sept. 7, 1938?
Mr. Leahy:—Don't lead.
Mr. Kelleher:—All right. I was just trying to do what you suggested; to save time.
Mr. Leahy:—You were not worrying about doing what I had suggested.

By Mr. Lewin:

Q.—What happened on Sept. 7, 1938? *A.*—I was rather late coming home from the office that evening and I was home a very short time when the telephone rang. I imagine the time would be after 6:30, the telephone rang, and I was informed by a woman's voice—
Mr. Leahy:—Object to anything she was told.
THE COURT:—Yes.

By Mr. Kelleher:

Q.—What did you do as a result of that telephone call? *A.*—I went to the Emergency Hospital, because I had been informed—
Mr. Leahy:—Same objection.
Mr. Kelleher:—Don't repeat the conversation.
The Witness:—Went to the Emergency Hospital and found my mother in the intake department of the Emergency. I found that she had—
Mr. Leahy:—I object; it must be based on hearsay.
Mr. Kelleher:—All right.

By Mr. Kelleher:

Q.—Did you talk with the intern at the hospital? *A.*—I talked with the intern at the Emergency as soon as I found the one who had examined mother and found that he had examined her, and that he had stated that there were no broken bones he could find; that there was no concussion, but that she was suffering badly from bruises and cuts. I immediately asked to have my own doctor brought in. This man said that there was another intern who wished to see her, a Dr. Harris, and I said, "How soon?" Naturally I was very much upset. The doctor said it would probably be an hour, that the doctor was already in the hospital, but that he had to eat his dinner. I wasn't anxious to wait an hour to have my mother further examined, and continued to insist on having my own doctor come in. He said I could phone him. I immediately went to the phone I was directed to and called Dr. Selders. Dr. Selders informed me—
Mr. Leahy:—I object to any conversation.
THE COURT:—Yes. Don't tell the conversation.

By Mr. Kelleher:

Q.—Did you ask Dr. Selders to come over?
Mr. Leahy:—We object; the Court has just ruled on that.
THE COURT:—Don't state what Dr. Selders said. She may answer as to whether she requested Dr. Selders to come.
The Witness:—I asked Dr. Selders to come immediately, and found out that he could not, and that I should go to the hospital authorities to make arrangements for his coming. I immediately went to the superintendent's office, was told that it was after hours, and that the general superintendent was not there. I was referred to the night superintendent, a doctor named McKeever—I believe his name was; I went to see Dr. McKeever and asked to have my doctor brought in.

Q.—Did you explain any circumstances? *A.*—I explained that the case was an emergency case, and that my mother was at that time in the intake department, having no attention whatsoever, except that one intern had looked her over. Can I say what the doctor told me?
Q.—Yes, proceed. What did Dr. McKeever say? *A.*—Dr. McKeever wanted to know who my doctor was. I said, "Dr. Selders." He said he didn't know him. I explained that he was Dr. Raymond E. Selders, the Medical Director of Group Health, of which I was a member. He looked in a file over in the corner and came back and said that Dr. Selders' name was not in their list. I said, "Just what does that mean?" He said that Dr. Selders would not be admitted to their hospital. I said, "Well, my mother—" Just then my husband came in and heard that remark and said something. I spoke up and said, "I have explained this to Dr. McKeever. This is an emergency and my mother is an emergency case, and it is my understanding in emergencies we can have our own doctor in."
Dr. McKeever said he was sorry, it didn't make any difference whether it was emergency or not. Dr. Selders couldn't come in. I said, "But I thought the whole point in this controversy was that we were to have the free choice of physicians"; that he was my surgeon and I wanted Dr. Selders. He said, "I am sorry." My husband said, "Perhaps he is working under orders." I said, "Is that so?" He said, "Yes." I said, "Perhaps it would be good for me to go to the superintendent." He said, "No, it wouldn't do any good to see him; the orders would be the same." I said, "I want my surgeon to look over my mother." The doctor said he could do so in the intake department but as far as giving any orders or doing any work, treating her, it would not be permitted. I said the best thing I could do would be to find out from Dr. Selders what he would recommend.
Q.—Before you leave that conversation, did Dr. McKeever suggest any other doctor? *A.*—Yes, he did. He went over to the corner when I said this about the free choice of physicians. He said, "We have a whole list of doctors here. You can have your free choice." I said, "I suppose I will go over and close my eyes and go down the list." He said, "You can move your mother to any hospital in the city if you wish." I said, "Could we be assured we would receive any different treatment in any other hospital?" He said, "No." I called Dr. Selders again at that time.
Q.—Without telling what Dr. Selders said to you, will you tell the jury what you told Dr. Selders?
Mr. Leahy:—I object to that.
THE COURT:—I don't think that is competent; sustained.

By Mr. Kelleher:

Q.—What did you do after you talked with Dr. Selders? *A.*—I went back to see my mother and found her in a very high state of—in fact, near nervous collapse, because of the treatment she had been subjected to. It had now been something like two and a half or three hours, and she was without treatment; and she was insisting on being taken home. She wanted to get home, because of the action—
Mr. Leahy:—I object to the qualification by the witness.
THE COURT:—Yes; let us get along.

By Mr. Kelleher:

Q.—All right, what did you do? *A.*—I went back and talked again to the intern and found that this Dr. Harris had examined her in the meantime, while I was talking to the superintendent, and I talked to both these doctors and they both assured me there were no broken bones and, so far as they could see, no concussion, although they could make no definite statement on that, but because of conditions there I made the decision to move my mother that night.
Q.—Did you do so? *A.*—I did, as soon as I could get an ambulance to take her home when she was examined by her own surgeon.
Q.—About what time did you get her home? *A.*—Between 9 and 10 o'clock.
Mr. Kelleher:—No further questions.

CROSS EXAMINATION

By Mr. Leahy:

Q.—Are you still employed by the Agriculture Department? *A.*—Yes.
Q.—And when did you join G. H. A.? *A.*—February of 1938.
Q.—Did you ever hold office in G. H. A.? *A.*—Yes.
Q.—What office do you hold? *A.*—I am at present one of the Board of Directors.
Q.—How long have you been on the Board of Directors of G. H. A.? *A.*—One year, a little over. Our election is in January.

Q.—So you are presently one of the Board of Directors, or is it Board of Trustees? A.—Board of Trustees. Board of Trustees or Directors.

Q.—When was it that this accident occurred, if you recall? A.—In September, the early part of September, the 7th. Late in the evening, during the heavy traffic hours.

Q.—And you would say it was about what time? A.—It must have been—in fact, I could give you the exact time, because I happened to look. The call came at 5:19, but they didn't call me until 6:35.

Q.—Were you home? A.—I wasn't at home, and there was no call until 6:35, because my maid was home and there was no call.

Q.—All you know about that is what you heard from your maid? A.—Yes, but I do know this: I asked the girl when she telephoned me what time my mother was brought in. She said 5:30. I said, "Why didn't you call me?" and she said they had been having difficulty, or something.

Q.—Were you living at Foxhall Village at the time? A.—Yes.

Q.—And you immediately went down to the hospital? A.—Yes.

Q.—And you found that an intern had examined your mother? A.—Yes.

Q.—And he said he wanted another doctor to look her over? A.—He didn't say he wanted another doctor. He said another doctor should do it.

Q.—What was his name? A.—Harris.

Q.—And what was the other intern's name? A.—I do not know.

Q.—Did you ask him? A.—No, but I remember "Dr. Harris," because he introduced him to me.

Q.—How long were you talking to Dr. McKeever? A.—Well, you see, I got to the hospital about ten minutes to seven, I presume. I was talking to the intern and nurses and my mother—It might have been 20 minutes, 25; perhaps not that long; I couldn't be sure.

Q.—And in the meantime, while you were talking to Dr. McKeever, Dr. Harris had also examined her? A.—Yes.

Q.—And they both stated, as far as they could determine without x-ray, there were no broken bones or anything of that kind? A.—Yes.

Q.—Do you recall what position Dr. McKeever had in that hospital at that time? A.—I was told he was the assistant night superintendent. The night superintendent. He is the assistant superintendent and the night superintendent.

Q.—Did you know Dr. Selders pretty well at that time? A.—Only as you would know your physician. I am rather a healthy specimen and I had not much occasion to meet him.

Q.—Did you know him? A.—Yes.

Q.—How many times do you think you had talked with him before?

Mr. Lewin:—I think that is immaterial.

THE COURT:—I think so.

Mr. Leahy:—I just want to know.

Mr. Lewin:—I know you do, but it is immaterial, and I object to it on that ground.

THE COURT:—It seems immaterial, unless you have some object.

Mr. Leahy:—It is only preliminary.

THE COURT:—Sustained.

Mr. Leahy:—I don't want to transgress your Honor's ruling, but may I approach the bench?

THE COURT:—Yes.

(Thereupon counsel for all parties approached the bench.)

By Mr. Leahy:

Q.—You had talked with Dr. Selders, had you not? A.—Yes.

Q.—How many times had you discussed the matters with him? A.—Discussed matters?

Q.—Yes. A.—Anything at all?

Q.—Yes. A.—On numerous occasions, I imagine.

Q.—Most of these matters were with reference to the controversy which had existed between the hospitals and G. H. A.; isn't that true? A.—No.

Q.—Had you ever discussed that? A.—I never had until we discussed it on the telephone that night.

Q.—With whom had you discussed the matter of emergency calls? A.—Dr. Selders told me that night; he said the superintendent would give me the right to have my own doctor there because it was an emergency.

Q.—Was this before you talked with Dr. McKeever? A.—Yes, he had instructed me to see the superintendent.

Q.—Did you know at the time that Dr. Selders was not on the courtesy staff of the Emergency Hospital? A.—I don't think I knew it; I don't know why I should have.

Q.—Did you know what he meant when he said that this was an emergency case, and when you said to Dr. McKeever, "It is my understanding that I have the right to my own doctor if it is an emergency case"? A.—I would think the case was an emergency, and my understanding of the word, so far as the dictionary definition of it was concerned, from that it was certainly an emergency case. Is that what you are trying to bring out?

Q.—That is what your understanding was? A.—Yes.

Q.—Did they offer to have any doctor in the hospital look your mother over? A.—No, not in the hospital.

Q.—Did you look in the list to see what doctors were there? A.—No.

Q.—Did there seem to be quite a number? A.—It was a filing cabinet; one of those that turns around, but about this time I was rather upset myself.

Q.—Did you then talk to Dr. Harris when you got back to the intake department? A.—Yes.

Q.—And after receiving the word that there were no bruises, broken bones— A.—(Interposing) There were serious bruises and cuts.

Q.—But no broken bones? A.—That is correct.

Q.—Then you called for an ambulance and took your mother home? A.—I asked Dr. Harris about an ambulance. He said they had no such service; then I got in touch with a private ambulance.

Q.—Was that Mr. Hines? A.—Yes.

Q.—And then did Dr. Halstead see your mother at home that evening? A.—Dr. Halstead came immediately.

March 4—Afternoon

TESTIMONY OF LOUIS F. THOMPSON

DIRECT EXAMINATION

By Mr. Kelleher:

Louis F. Thompson said he was employed with the Home Owners Loan Corporation in March 1938, temporarily assigned to assist in setting up the records of the Group Health Association.

Q.—I show you Exhibit 463 to 468, inclusive, for identification, and ask you whether you signed Mr. R. T. Berry's signature on those letters? A.—With my initials under the signature; yes, sir.

TESTIMONY OF KENNETH D. ARMSTRONG

DIRECT EXAMINATION

By Mr. Lewin:

Kenneth D. Armstrong said he was in May of 1929 a notary public of the District of Columbia. He identified the signature of Dr. Thomas E. Mattingly.

TESTIMONY OF SAMUEL H. ROGERS

DIRECT EXAMINATION

By Mr. Lewin:

Samuel H. Rogers said he was president of the Board of Directors of Casualty Hospital in 1938. He identified signatures, minutes, roster of the staff, committees, etc.

TESTIMONY OF DR. FRANCIS X. RICHARDSON

DIRECT EXAMINATION

By Mr. Lewin:

Q.—When you were on the stand before, I believe you testified that you resigned from your position with Group Health Association on July 15, 1938? A.—Yes, sir.

Q.—And I believe we identified your written resignation? A.—Yes, sir.

Q.—Dated July 15, 1938? A.—Yes, sir.

Q.—Now, without stating what anybody else said to you, tell the jury what was the immediate reason that you had for resigning when you did. A.—The reason that I resigned was because of the conversation which I had with these men.

Q.—Without telling us about that conversation, what was the reason that resulted from it that caused you to put in your resignation? A.—I hardly see how I can answer that question without discussing what was said.

Q.—But you are not permitted to do so. We have got to get your answer from your own mental processes.

Mr. Leahy:—Ask him the direct question.

By Mr. Lewin:

Q.—Did you resign from Group Health Association on that date because you were afraid you might lose your hospital privileges? *A.*—Yes, sir.

Q.—That was your reason? *A.*—Yes.

CROSS EXAMINATION

By Mr. Leahy:

Q.—You told us you went to work for G. H. A. some time in the year 1937, did you not? *A.*—Yes, sir.

Q.—You had privileges in what hospitals? *A.*—Sibley, Providence and Garfield.

Q.—And you had them, did you not, on July 15, 1938? *A.*—Yes, sir.

Mr. Lewin:—May it please the Court, before we approach the bench on the offer which has already been made, I would like to make some additional offers and then we can approach the bench in one fell swoop.

THE COURT:—Very well.

Mr. Lewin now offered additional exhibits.

(The jury withdrew from the court room. Counsel approached the bench and conferred with the Court.)

Mr. Kelleher then offered sections from the Proceedings of the House of Delegates of the American Medical Association for 1938, report of the Secretary, report of the Reference Committee on Reports of Board of Trustees and Secretary, page 58, and the official action with respect to this report, appearing on page 60. the Report of the Board of Trustees, marked in red pencil on pages 7, 8, 29, 30 and 31, together with the portion of the Report of the Reference Committee on the Reports of the Board of Trustees and Secretary appearing on pages 58, 59 and 60, and the action of the House of Delegates on the report of the Reference Committee, appearing on page 60. He offered also the report of the proceedings of the House of Delegates in 1931. The portion of the Report of the Board of Trustees, appearing on page 19, together with the portion of the Report of the Reference Committee on Reports of the Board of Trustees and Secretaries, appearing on page 35, and the action of the House of Delegates approving the Report of the Reference Committee, appearing on page 35; also the portion of the Report of the Judicial Council, appearing on page 24, together with the portion of the Report of the Reference Committee on Rules and Order of Business, appearing on page 40, and the action of the House of Delegates on the latter report, appearing on page 40. He offered also the report of the proceedings of the House of Delegates for 1932, the portion of the Report of the Board of Trustees appearing on pages 15 and 16, together with the portion of the Report of the Reference Committee on Reports of Board of Trustees and Secretary, appearing on page 46, and the action on the latter report by the House of Delegates, appearing on page 48; also the report of the Reference Committee on Medical Education appearing on page 40.

Mr. Kelleher also offered the portion of the report of the Reference Committee on Medical Education, appearing on page 40, and the action of the House of Delegates on the report of that committee, appearing on page 41. Then he offered the report of the proceedings of the House of Delegates for 1933—from that report, in addition to what has already been offered and received, the resolution of Mundt, appearing at page 50, together with the Report of the Reference Committee on the Mundt Resolution, appearing at page 56, and the action of the House of Delegates on the report of the Reference Committee appearing on page 57.

Next he offered the report of the proceedings of the House of Delegates for 1934, the Report of the Special Committee appearing on page 55, together with the action of the House of Delegates dealing with the report, appearing on page 55. He also offered the proceedings of the House of Delegates for 1935, 1936 and 1937; the portion of the report of the Judicial Council appearing on page 30; so much of the Report of the Reference Committee on Reports of Officers, to which the Report of the Judicial Council was referred, pages 40 and 41 of the Proceedings; the action of the House of Delegates upon that portion of the Report of the Reference Committee, appearing on page 41; the portion of the Report of the Council on Medical Education and Hospitals, appearing on page 31; the portion of the Report of the Reference Committee on Medical Education appearing on page 37; the action of the House of Delegates upon the report of said Reference Committee, appearing on page 38; that portion of the Report of the Reference Committee on Medical Economics appearing on page 46; the action of the House of Delegates upon the aforesaid portion of the report of said Reference Committee, appearing on page 47; that portion of the Special Report of the Bureau of Medical Economics appearing on pages 56, 59 and 60; that portion of the Report of the Reference Committee on Medical Economics appearing on page 63, and the action of the House of Delegates on the said portion of the report of said Committee, appearing on page 64.

The Government also offered in evidence the proceedings of the House of Delegates for 1936: These portions of the Report of the Board of Trustees appearing on pages 7, 20, and 23, that portion of the Report of Reference Committee on Legislation and Public Relations, to which the portion of the Report of the Board of Trustees appearing on page 23 was referred, appearing on page 51; those portions of the Report of the Judicial Council appearing on pages 36 and 37; those portions of the Report of Reference Committee on Reports of Officers, to which Reference Committee the Report of the Judicial Council was referred, appearing on page 47, and the action of the House of Delegates on said portions of the Report of said Reference Committee, appearing on page 48; that portion of the Report of the Council on Medical Education and Hospitals, appearing on page 38; that portion of the Report of Reference Committee on Medical Education appearing on page 45 and the action of the House of Delegates on said report, appearing on pages 45 and 46; that portion of the Proceedings entitled "Membership in County and State Associations for Members of Staffs of Hospitals," appearing on page 60.

The Government also offered the proceedings of the House of Delegates for 1937: The portion of the Report of the Board of Trustees appearing on pages 22, 23, 24, and 25, that portion of the Report of Reference Committee on Legislation and Public Relations, appearing on page 68; the action of the House of Delegates on that portion of the report of said Reference Committee appearing on page 68; that portion of the report of the Judicial Council appearing on pages 39 and 40; the Report of Reference Committee on Amendments to the Constitution and By-Laws, appearing on page 74; that portion of the Report of the Council on Medical Education and Hospitals, appearing on page 41; that portion of the Proceedings entitled "Proposed Amendments to the Principles of Medical Ethics," appearing on page 53; that portion of the Report of Reference Committee on Amendments to Constitution and By-Laws, appearing on page 64 and the action of the House of Delegates on said portion of the Report of said Reference Committee, appearing on page 65.

Mr. Lewin:—The Government would like to reserve the right, at the appropriate time, to ask your Honor to extend to all of the defendants as to whom a prima facie case may have been made out certain of the evidence which was offered against individual defendants.

THE COURT:—That will come later.

Mr. Lewin:—I should like now to read to the jury U. S. Exhibit 587.

Mr. Leahy:—May it be the instruction, your Honor, that this is admissible only against the writer of the letter?

THE COURT:—Yes; I think so.

U. S. EXHIBIT 587

Mr. Lewin:—This is a letter from the defendant Thomas E. Mattingly addressed to William R. Beall, Foreman, Special Grand Jury, dated Nov. 13, 1938:

"Gentlemen of the Grand Jury:

"I hope that you will not think that this second communication implies any fear on my part that my first letter did not or will not get just consideration and appropriate action. Rather it is written to provide you gentlemen with specific data, whereby I hope to persuade you (even should the Public Prosecutor object) that you, as a fact finding body, could not in justice, honesty or fair play ignore my plea as a reputable physician, a native son and a life long resident of the District of Columbia, for a hearing. I purposely add the comment, 'even should the Public Prosecutor object,' because I am fearfully of the belief that he will use every device at his command to keep you from learning the whole truth, undistorted by political prejudice and intellectual dishonesty. It is my personal opinion that if the Public Prosecutor had knowledge or even a well founded suspicion, that the testimony of a witness subpenaed before you, might weaken or break his case, he would not be above the legalistic trickery of attempting to persuade you, 'that the status of the witness had already been investigated and such testimony as they might be able to give, is both irrelevant and inconsequential.'

"Because I have an abiding faith in your civic honesty, your democratic concept of justice and your staunch, incorruptible courage, I promise if allowed to appear before you and under your sovereign protection, to acquaint you with what is in the hearts and minds of this community of physicians which has motivated us to do as we have done. I am sure you will agree, that before you can with honesty and conscience indict us, you must make every effort to

ascertain the true reasons behind this concerted but spontaneous action of a preponderant majority of the physicians of Washington. Only when and if you have weighed and considered those motives, can you return a true and uncorruptible verdict. Because I trust you, have faith in you, I promise if given an opportunity to appear before you to truthful answers [sic] without any evasion or reservation whatsoever.

"That you might know beyond any reasonable doubt and despite any objections on the part of the Public Prosecutor that my testimony is both relevant and consequential, I frankly admit the following acts of professional leadership, successfully accomplished.

"1. I personally raised the question and forced the issue of compelling wavering or undecided hospitals to deny courtesy privileges to staff members of G. H. A. I likewise successfully argued the point in an Executive Session of the Medical Society that we had ample precedent to discipline any member of our society found guilty of secretly aiding G. H. A. in obtaining its objectives by subterfuge. The threat of this action alone enjoined the clandestine cooperation of several members suspected of such cooperation, though it must be noted that these members were never openly named because such suspicion we had, was hearsay evidence only, and as such was not admissible.

"2. I successfully used my position as a member of the Medical Council to prevent Dr. Raymond Selders from receiving courtesy privileges at Sibley Hospital.

"3. I was the author, sponsor and lone defender of the defeated substitute motion which would have punished Dr. Scandifio with suspension, instead of expulsion from the Medical Society.

"Obediently,
"Thomas E. Mattingly, M.D."

May it please the court, with the reservation of the right to introduce at the next session such items of evidence as we may have overlooked, the Government at this time rests.

THE GOVERNMENT RESTS

THE COURT:—Have there not been some letters and papers that have gone in recently that ought to be read?

Mr. Lewin:—No; I do not think so. Lots of them were cumulative things that we did not expect to read.

THE COURT:—I thought if you did want to read them I would like to take the time to do it now.

Mr. Lewin:—No, your Honor. We do not plan to read them unless counsel for the defendants want them read.

THE COURT:—I suppose counsel for the defendants are ready to proceed?

Mr. Leahy:—I would like to proceed to get a little rest, your Honor.

THE COURT:—Members of the jury, counsel have conferred with me, anticipating that the Government would probably close its case today, and have indicated a desire, on both sides, to do some work outside of the court in order to prepare for the next turn in the case. After discussing it with them it perhaps is not only fair to them but probably, in the end, it will also save some time, if I do give them a day for that purpose. So I am excusing you and adjourning the case until Thursday morning.

MARCH 6—MORNING

TESTIMONY OF FRED O. COE

DIRECT EXAMINATION

By Mr. Kelleher:

Q.—You have been on the stand before, have you not? *A.*—Yes, sir.

Q.—You are from Georgetown University Hospital? *A.*—Yes.

Q.—And secretary of the Executive Staff and were during 1938? *A.*—Yes.

The witness identified his letter to Dr. Raymond E. Selders, dated March 4, 1938.

(Here followed extended discussion at the bench over admission of a carbon of a letter from Holman Taylor to the Board of Censors of Harris Co. Medical Society taken from Dr. Leland's file. It was not admitted.)

(A letter from Dr. Leland to Dr. Saville was admitted.)

TESTIMONY OF HELEN E. SWANSON

DIRECT EXAMINATION

By Mr. Kelleher:

Helen E. Swanson said she is employed by George Washington University Hospital as Secretary to the Medical Director, Dr. Bloedorn.

(She identified roster of the hospital, committees, staffs, etc., also a record of membership of the staff in the District of Columbia Medical Society. All were received in evidence.)

Also received were Conklin letters of July 29, 1937, and December 2, 1937, together with enclosures.

Attorneys for the prosecution notified the Court of certain corrections in the record.

MOTION FOR A DIRECTED VERDICT ON BEHALF OF THE DEFENDANTS

OPENING ARGUMENT ON BEHALF OF THE DEFENDANTS

WILLIAM E. LEAHY

Mr. Leahy:—If you Honor please, we wish to interpose at this time a motion for a directed verdict as to all of the defendants on the entire case as made out by the prosecution up to this time. I thought that perhaps in the economy of time and also in a more orderly presentation of the case I might present to your Honor the case with reference to certain of the defendants first. I mean by that, the individual defendants.

LEON ALPHONSE MARTEL

First, I would bring your Honor's attention to the defendant, Leon Alphonse Martel. I have looked over the record in this case carefully with reference to any testimony which might relate to him in any manner, even most remotely, to show that he was engaged in any unlawful conspiracy such as is detailed or outlined in the indictment. I find no evidence whatsoever which could connect him in any way with the conspiracy. For that reason I say that as to the defendant Leon Alphonse Martel there is no evidence to show that he is in any wise connected with the conspiracy, and therefore that as to him the motion is proper.

R. G. LELAND

Take the one immediately before that—Dr. R. G. Leland. There is no evidence in the case, as I recall it, other than the letters which were written in the shape of answers by two men who worked in the Bureau of Medical Economics. Those letters went in under the background theory of the indictment. They were not offered in proof of the charge of the main case. In other words, they were introduced on the theory on which your Honor admitted them, that they tended toward establishing those allegations in the indictment which set forth the general background, but not in any way in the charging part of the indictment itself. There is no letter other than the one which was presented to your Honor this morning in the shape of a green carbon copy which shows any connection of Dr. Leland personally with this conspiracy. If I am wrong about that I shall be glad to be corrected, because my recollection, and the search which I have made of the many documents in the case, is to the end that Dr. Leland never personally wrote these letters, but that those in his department wrote them, and as I understand, the question was put under his authorization and direction as he was the general supervisor of that department. These letters relate in no wise to the charge of conspiracy as cast, and relate entirely to that portion of the indictment which concerns the background. Therefore there is nothing moved up from the foundation which was laid in the shape of background into the charging part of the indictment itself in so far as Dr. Leland is concerned.

The letter which was introduced this morning, written in December 1937, merely shows that there had come to Dr. Leland's attention this bit of information that the Comptroller General had ruled that a loan made by H. O. L. C. was improper or illegal. Now, certainly on that information which had come to him it cannot be charged that he had first knowledge of the scope of the conspiracy and, secondly, that he had entered into the conspiracy for the purposes charged in the indictment.

MORRIS FISHBEIN

Now, if we move up further we find Dr. Fishbein in the same list. There is no evidence that Dr. Fishbein wrote anything in this case except, as I recall that some time in the fall of 1938 he wrote a letter to a Dr. Hammerly in which he stated that Hammerly's letter had been referred by him, Dr. Fishbein, to another bureau of the American Medical Association because it was the interested bureau.

The only other evidence in the case, as far as Dr. Fishbein is concerned, is the evidence that he was the editor of THE JOURNAL. It may be stated or argued that because Dr. Fishbein was editor of THE JOURNAL and because THE JOURNAL in October printed an article which was written by Dr. Woodward, that therefore Dr. Fishbein had knowledge of this entire conspiracy as alleged in the indictment; that he entered into the same; that he continued a member of the alleged conspiracy, and that he is chargeable with all of the allegations against all of the conspirators in this case.

There is absolutely no evidence against him in the shape of any writing on his part. There is nothing whatsoever to indicate that he knew anything about the conspiracy. The article came into THE JOURNAL as other articles come into THE JOURNAL. If it happened to concern G. H. A. that does not mean that Dr. Fishbein is chargeable with the scheme or com-

bination that is alleged in this indictment and that he entered into it and continued therein as a conspirator from that point down. There is not a line in the record to connect any one of those three defendants in any way, shape, or form with the conspiracy as outlined here.

DR. WALLACE YATER

If we pass now to page 3, we have Dr. Yater. There is no evidence against Dr. Yater of any activity whatsoever except a lone motion which he made or which was reported to have been made by him in one of the minutes introduced in evidence. Beyond that there is no line whatsoever of evidence, as I recall it, which connects Dr. Yater in any way, shape, or form as a conspirator in this case. The evidence is entirely silent except for that single motion.

WILLIAM JOSEPH STANTON

The same is true with reference to the defendant William Joseph Stanton. I believe he made a motion at one time in one of the meetings of the District Medical Society that there should be a committee appointed to go out to the American Medical Association and see what could be done with reference to G. H. A., and report back.

EDWARD HIRAM REEDE

There is no evidence against Dr. Reede whatsoever, except that he sat in the trial of Dr. Scandiffio. That trial was had, if your Honor please, by the Executive Committee of the District Medical Society. Dr. Reede was a member of the Executive Committee. There is nothing which Dr. Reede said in any meeting; there is no action which he took; there is no conduct which can be charged to him whatsoever in relation to anything done with respect to any of the acts which the Government offers as ground for the proof of this conspiracy, save and except that he sat there as a member of the committee which tried Dr. Scandiffio.

As I recall it, there is in evidence at this time the constitution and by-laws of the District of Columbia Medical Society. If there is not, we have in evidence the report which was made in connection with the Scandiffio case which is the evidence on which and through which the conduct of Dr. Reede must be examined, analyzed and read to determine whether or not he has any connection whatsoever with this conspiracy.

The Executive Committee, under the constitution, is the one which is charged with the examination of charges preferred or recommended against any member of the District Medical Society or any question of discipline involved. The Executive Committee does not originate the charges, but they come over to that committee from the committee which has been known or identified as the C. C. & I. M. Committee.

In this case there came in the ordinary course of procedure and in accordance with the District Medical Society's constitution and by-laws information in the shape of a recommended charge against Drs. Scandiffio and Lee. Dr. Reede, in accordance with the duties placed on the Executive Committee, sat in the meetings which heard evidence in the Scandiffio case.

There is no evidence whatsoever to charge Dr. Reede with any knowledge that that particular disciplinary trial which was had with reference to Scandiffio had any connection whatsoever with any particular combination, scheme or confederacy under this indictment.

If an individual defendant can be held responsible for a single isolated act which the prosecution picks out as an act which fits into a picture, and then charges that individual defendant with the entire picture, then no one would dare to do anything or could legally do anything in connection with such a charge of conspiracy.

But the prosecution must go one step further. First, they must prove the underlying conspiracy. Having proved the underlying conspiracy, they must bring the knowledge of that home to the individual defendant charged. Having brought the knowledge of it home, then they must go one step further up the ladder and prove that, pursuant to that knowledge and with full possession of it, that individual defendant did something in the furtherance thereof. Merely to prove that an individual defendant did an isolated act which later on, under the scheme or theory of the prosecution, might have fitted into the general picture, does not bring criminal responsibility on that individual defendant solely because he did only that isolated act. They have no proof that Dr. Reede or Dr. Stanton or Dr. Yater had any knowledge of the general picture as presented and painted in this indictment. They only prove that with respect to each an isolated act was done. It was done for the specific, definite purpose not of the general conspiracy, but to complete, we have shown, the isolated act for which that particular individual at that time was either responsible or in the conduct of which he was engaged.

For instance, Dr. Reede was engaged in the trial of Dr. Scandiffio. Dr. Stanton was engaged in making a motion, because he wanted a definite thing done, according to the motion; he wanted to find out the attitude of the American Medical Association, whether the American Medical Association would cooperate or assist.

Dr. Yater made a motion which is so unimportant that there could not be charged to him any knowledge whatsoever if a conspiracy or any act done in furtherance of it.

What I wish to state to the court—and perhaps I am doing it very poorly—is, emphatically, that the prosecution cannot hope or expect to hold individual defendants in this charge of conspiracy unless they first prove the underlying charge of conspiracy applicable to each one of them. Then, having proved that, they must go one step further and show that that defendant, with full knowledge of that particular conspiracy, then and there did the individual act or a few acts or three acts, whatever the individual defendant may have done in furtherance of and in pursuance of that conspiracy.

Furthermore, they must prove that it was done with the intention of furthering the conspiracy. If, for instance, an individual defendant may have committed an act which he was under obligation to perform, and in the performance of which he was engaged, and the result of that may have an interpretation placed on it by the prosecution construing it to be in furtherance of the conspiracy, nevertheless, unless they go one step further and prove that the individual defendant intended that act to further the conspiracy when he did it, the act is not binding against him as a conspirator and it is not evidence that he was such.

In no place in this proof will it be found that in this sweeping charge which they have made, this drag-net against all the individual defendants solely and only because they may have done individual acts, do they prove that there was the cohesion which we find where the other conspirators gather or assemble together. They have taken the individual blocks, set one up against another, and they ask your Honor to believe that those cease to be individual blocks, and that they are all one board, charged against all those who have taken any part whatsoever therein.

Now, as I recall the testimony against Dr. Young it relates only and solely to the point that he was on a credentials committee, or on some committee, of the Eastern Dispensary & Casualty Hospital during a portion, if not all, of the time covered by this combination, which is charged.

They don't charge that Young in this charge of conspiracy with having done anything more than that in connection with the Dr. Selders' application to the Eastern Dispensary, it was denied; and that he was on some committee in Casualty Hospital which had come before it the question of that application in some form or other. A good deal of debate was had in connection with the criminal responsibility of the hospitals, as hospitals, in this connection before any of that evidence came in. Now, we find a rather amazing situation with the hospitals. It is very bothersome: bothersome as a matter of law, and bothersome because of the confusion about it in the record, and it leaves counsel in the situation where it is difficult by taking any portion of the evidence and directing the Court's attention to it, to show we depend upon this particular piece of evidence or that, but if this record discloses one thing above another, it is this: that each hospital is a separate, distinct, legal entity. That hospitals, as hospitals, as separate, distinct, legal entities are charged with being conspirators. Their staff are not charged as conspirators, either general, special or courtesy staffs are not charged; their various executive committees or councils, or boards of directors, or trustees are not charged. It is the hospital qua hospital, as a legal entity, which is charged as a conspirator in this case. Therefore, the hospital, as a hospital, a legal entity, can be criminally bound only if the hospital as a hospital and legal entity acts.

The second thing which is clear in this record is that the administration of the hospitals, as such, and as corporate entities, is had through responsible administrative lay boards. The medical staff can do nothing to bind the hospital as a hospital. I don't care whether you call it an executive committee; whether you call it a council; an advisory board, a medical staff, or by what name it is identified, the fact of the matter is that the executive committee of doctors, the medical staffs, courtesy or regular, had no more power to bind the hospital in a corporate act than a stranger has to do the same thing, and there isn't a single corporate act of the hospital which has

been taken in this case, and which has been proved in this case except ones made by the administrative lay board of the hospital; and I think it is a fair statement to make to the Court—I don't wish to misrepresent the testimony or mislead—but I think I cannot be criticized for making the statement if I say that the boards of the hospitals mentioned in this indictment are appointed, not by any medical staff, not by any courtesy staff, not by any recommending committee of doctors, but by a lay administrative board. Therefore, the corporate act, the hospital act, binding any hospital here, to determine whether or not it is a conspirator, is the act of the administrative board; and there isn't a line of evidence which charges a single member of the administrative board in this case with any act done with knowledge of this conspiracy, or in furtherance of it.

We have as the administrative boards perhaps imposition—let us put it for the sake of argument, imposition by the medical staff—maybe there was a quiet little understanding in the medical staff that they would recommend to the administrative board that Dr. Selders should not be appointed to the staff. Let us take it the full way, the way the prosecution would like to have it presented—that there was no foundation in fact or inference for the rejection of Dr. Selders to the staffs of the hospitals, notwithstanding which these little executive groups, or a membership committee—advisory in jurisdiction—possibly, as a result of such agreement among themselves, with no right or reason—recommended to the administrative boards that Dr. Selders be rejected, and the administrative boards follow that recommendation, and the hospital acts through its administrative board, and says Selders is rejected. Does that make the hospital a conspirator? Of course not. The hospital may have been imposed on, but before the hospital can become a conspirator it must have known of the conspiracy; it must have acted in furtherance of the conspiracy, and intentionally so. Therefore, if an administrative board has been imposed on by anybody which may recommend to it such action, and the administrative board follows that advice, then it is in the situation, perhaps, of having accepted bad advice, but that doesn't make it criminally responsible as a conspirator, and there isn't a single line in the case which shows any hospital, through its administrative board, with full knowledge of this conspiracy, of its scope, its purposes, and intent, intentionally took any act with respect to any member of this staff knowingly intending to further or do anything in connection with this conspiracy itself.

Now, those points were not before your Honor when the broad question was argued as to whether or not the hospitals could be brought in as conspirators. They cannot be so brought in because Dr. Smith happens to be on the staff of the hospital, and Dr. Smith is a member of the Medical Society, and Dr. Smith says something against Dr. Selders. That does not bind the hospital as such. It cannot be if an executive board acts in a certain manner in making a recommendation and some, or if all, of the executive committee members, whether on the medical staff or board of the hospital, and being members of the American Medical Association or District Medical Society. They must be one step further and show that the responsible binding officials, with authority to bind the hospital, have bound it in some way with knowledge of this conspiracy, in scope, intent and purpose, and having that full and complete knowledge had cooperated in the manner charged to accomplish the illegal end intentionally and knowingly.

Now, with that fundamentally in the case, with reference to the lack of proof binding the hospitals as conspirators in this case, simply because some member happened to write a letter, or someone else on a particular staff who may like the title on the staff and uses it in a particular letter, transports information which went from the hospital to a particular one of these G. H. A. members. That doesn't bind the hospital, nor make the hospital a conspirator in this case. Now, again bringing that thought back to the analysis of the testimony which concerns Dr. Young, we have here only that he acted as a member of an executive committee, or maybe as chairman—I can't recall which at this moment—but in any event he acted in a responsible position in some connection with the hospital to which he was attached. Maybe he was chief of staff; maybe chairman of the executive committee; maybe he was anything we want him to be, the point is what has he done? We know that the executive committee was composed of certain members of the profession. There hasn't even been an intimation, that with respect to that hospital, anything was done so far as changing the rules and regulations of it is concerned. We know that for fifty years that Eastern Dispensary had a regulation with regard to the right of the members of the medical profession to practice on its professional staff. Can there be any doubt about that testimony? We know that on this particular committee which passed on this application we had a couple of doctors against whom the prosecution has not had the temerity to charge them with the conspiracy. We know that Dr. Magruder MacDonald, Coroner of the District of Columbia, was on that committee, and that out of that committee came a recommendation against Dr. Selder's appointment.

Therefore, not merely is it true that there was a conspiracy, but the hospital itself becomes a conspirator. I submit we cannot go that far in the most enthusiastic support of the indictment. We cannot take it and say an indictment for a conspiracy is difficult to prove and can be established, in most instances, only by circumstantial proof and, therefore, every circumstance we offer ought to be construed as a sanction, and prima facie, one to establish those charges. We cannot do that. After all, each one of these defendants has a right involved in this case, a most serious and sacred right, so far as he is concerned. It doesn't seem to mean much when we come to take circumstances in this case, in the shape of documents, as to what these hospitals have done in the past. They don't want to have the Court take into consideration the presumption we have already mentioned, and through which this evidence must be strained under the law, and that is if these acts could have been done just as well in pursuance not of a conspiracy but of a duty, lawfully imposed on a defendant, then we cannot distort the act done into one done in furtherance of a conspiracy where there is nothing in the evidence to color it whatsoever.

Now, what did Dr. Young do?

THE QUESTIONNAIRE

Where is there anything in the proof to show his knowledge of the conspiracy? They pick up a questionnaire. They say, "There is the proof." Dr. Young was asked a question and he answered it. Now, there is no particular sanctity with which we surround a written document which causes its contents to be judged under different rules of law than the ordinary spoken word and, suppose in this instance, Dr. Warfield, who was the member of the committee on hospitals in the District Medical Society, had met Dr. Young in the street and said. "Doctor, how many men have you over there on the staff who are members of the District Medical Society, and how many are not"? Suppose he said, "Well, you know, for fifty years we have had a rule and under that rule usually the only doctors who can qualify are members of some recognized society." Does that make him know all that is said by the committee as such and by every member of it? Does that make him a conspirator in the sense that first he gave an answer of that sort to Dr. Warfield? He didn't invite it. He was asked the question, and I hope we still have the right to answer questions. I hope we don't have to evade them or play dumb when a question is asked about G. H. A. I hope that when someone meets another on the street, or writes a letter, that such person to whom the question is propounded or letter addressed will not be required to ignore or evade it, or not be permitted to give a true answer to it, or sit on a cloud like some cherub. If he answers honestly, as most men are presumed to answer, and do answer, if such answer is critical of G. H. A., does that make him a conspirator? Of course, that doesn't make him the subject of complete and full knowledge of this conspiracy as charged within the four corners of this indictment.

Now then, does that answer that had been given mean, not only, "Do you know about G. H. A., and all this, but when you answered that question you did it for one reason"? Just notice the stretch to which they push the Court. See how they try to make that as qualifying evidence against Dr. Young, and Dr. Young states—and where I say "Dr. Young," it is applicable to all the individual defendants—they say that because he made that answer that Dr. Young had only one purpose in his mind. That he made it with the intent in some way to assist or aid in the furtherance of the charges contained in this indictment. In other words, to hinder, impede, destroy—use any verb you may wish—G. H. A.

That is a long jump, if your Honor please, in the line of logic and reason. Because Dr. Young made those answers on the questionnaire, which are answers of fact: they were not lies, were not misrepresentations; they were not concealments; because he told the truth, this one doctor who was a member of a society committee—and I hope the District Medical Society has the right to be interested in the hospitals which they have built up and maintained for fifty years before somebody thought about G. H. A. I still hope the District Medial Society will under the Court's ruling not be shut off or barred from having some interest in the standards of our hospitals simply because of G. H. A.—and simply because the chairman of the hospital

writes a series of questions indicative of only one purpose, to obtain information, the accuracy of which if it be enclosed in a letter or the person to whom it is addressed answers those questions, therefore this prosecution says that the person who answered those questions had but one thing in mind, and that was an intent to further the charge as laid down in this indictment, to hurt G. H. A. Now then, let us go another step further. If there is one presumption which must be admitted, and which cannot be contradicted in any way under the law, it is this: that if we objectively segregate an act done, and all there is before the examiner is the act done, and we put on that act the microscope of the law, and we try to find its motives, and we find that we can under that examination and the analysis have a reason which comports with honesty of purpose in its performance just as well as we can find one which under the interpretation of those charging that act against the person, that it was done with improper motive, then the act must be construed along the line of honesty of purpose, because most men do act honestly and uprightly, and in accordance with the law; and when a charge of this kind is made against men who have spent lives without any implication of crime against them, it is only fair that they should have the benefits in this case, as in any ordinary case, of the protection which the same law gives to them for the violation of which they are being prosecuted.

Now, all the way through, if the Court please, and I say this as seriously as I ever said anything, I can't comprehend why it is that even in the argument on questions of admission of evidence, the prosecution won't grant to a single one in the American Medical Association, the District Medical Society, any single hospital, anybody in this wide world, any honesty of purpose in criticizing G. H. A. They are beset, they are simply overwhelmed, they are befuddled with the idea that if anybody criticized G. H. A. they are convicted by their very act—he is a crook, a criminal; and he had the basest of motives when he did it.

Now, take Dr. Young—using him as an example. They won't give to the executive committee which recommended against Dr. Selders any honesty of purpose; that, in fact, those people did in fact investigate him. Perhaps they did find out a little something about Dr. Selders, and perhaps those men who hold high positions in the District of Columbia and in this community, who have honorably, for a number of years, served the hospitals to which they are attached by being members of their staff, were not actuated by these evil motives. Perhaps they did, after investigating Dr. Selders, tell those hospitals, the standards of which they have maintained through the years, that they could not in justice to the patients, the public and the profession admit Dr. Selders to the privileges for which he made application. Now, that is the presumption with which we start out. Why should we say that Dr. Magruder MacDonald, because he has not been mentioned as a conspirator, why should your Honor be asked, if he did reject Dr. Selders' application, that he did so because he wanted to kick Dr. Selders out regardless of whether he was qualified or not, or because he was a member of G. H. A.?

If it wasn't in this forum, and if that information came to your Honor on the street, you would immediately say, "Dr. Magruder MacDonald had some reason for doing it. Let's find out the reason for it." Do we know? No. The prosecution leaves this evidence suspended in the air, and wants the jury to guess or accept an interpretation which will be so ably argued by the prosecution to them, and that is the danger against which the law protects, with reference to conspirators, particularly in this sort of a case where only circumstantial evidenced is urged against them, because, after all, the verdict will be based, not on the evidence and the reasonable inferences to be drawn from it, but the verdict will be based on those inferences which counsel on one side or the other, through his ability so to do, will persuade the jury they should draw. That is not the kind of a verdict we ought to have in any case. I submit you cannot find in the evidence against Dr. Young a common purpose to hinder, or destroy, G. H. A., or do anything to G. H. A., with any or between the other defendants in this case, in any way, shape, or form; and I say that is likewise true with reference to Dr. Yater, Reede, Martel, and Leland, and Dr. Fishbein of the American Medical Association. As to them the evidence is so sketchy as to be negligible, and any inferences to be drawn against them are so stretched beyond logic and reason that it would not be fair to hold those men in against this mass of documentary proof, in connection with which they have their evidence brought out against them. So far as Dr. Fishbein, for instance, is concerned, the District Medical Society may be swept out of existence; he doesn't know it exists; there isn't a line of evidence that he ever heard of the District Medical Society. He never talked to one; he never wrote to one; he never did any act with reference to any other act which the District Medical Society did or any of its members did. The same is true with reference to Dr. Leland. You can wipe the District Medical Society right off the list of those societies in existence, so far as Dr. Leland is concerned. He just doesn't know about it, but they wish to confuse the record by bringing in under this background theory this testimony in the shape of documents written by Laux and Simons in response to inquiries from people all over the United States with reference to various forms of practice of medicine, which were springing up in communities, in which those particular inquiries came from.

DR. A. C. CHRISTIE

Now, if we pass from that point on to the other defendants in this case—I am not going to name them name by name—but let us take Dr. Christie. Dr. Christie seconded a motion; that is what he did; he seconded a motion, but they will say to your Honor, "Yes" that is all, "but it was the resolution of Dr. Wilson," and that resolution they have considered to be so important that they have quoted it in the indictment.

There isn't another thing Dr. Christie did; that is everything he did. They have not proved that he was active in any way, shape, or form, in connection with anything else done in furtherance of this conspiracy, but in that lone, isolated act.

Now, let us examine that resolution, because we have heard so much of it; it is considered so important. What was the result of that resolution? They say it was adopted. That doesn't give it any more force or effect than it had by its terms. It was a resolution to go to a committee for examination, study, and report back. That is all it was. The Society couldn't take any affirmative step in the furtherance of the conspiracy, or in buying a dozen eggs, under that resolution. It couldn't have incurred an obligation under the law on the strength of that resolution. The only reason that it is in the indictment—and we know why it is there—is because it sounds bad. It may be good advertising, propaganda—and the indictment is not above propaganda in the case—because if we can find something in the resolution that sounds bad, something which the District Medical Society was doing against Group Health, we will spread it. It is just the same sort of a resolution which we make here before your Honor when we ask your Honor to take under advisement and study some action on a matter which is before the Court. I am asking your Honor now for a directed verdict. I am asking your Honor to take it under advisement as you sit here and listen. Am I doing something now to persuade your Honor to join a conspiracy against G. H. A. because, forsooth, I am asking that the conspiracy charge here be dismissed? The terms of that particular resolution do not do more than ask another committee of the District Medical Society to study and report back, and Dr. Christie seconded that kind of a motion. Negative action. In no way positive, save and except that whatever was done in that case would be done not in pursuance of that resolution but after careful study by a committee of the American Medical Association. Your Honor knows what that study brought forth. It brought forth the resolution of December 1st, and now they criticize that because they say it is camouflage. We did nothing except with the basest of motives, and with only one objective; to destroy G. H. A.

That is everything Dr. Christie has done, and because he seconded a motion for the adoption of a resolution which looked toward careful study and deliberation on the part of a committee he, therefore, now is charged with the full knowledge of this conspiracy, and the intention which he had in seconding that motion was to further this conspiracy, as alleged in this indictment.

Now, of course, one more thing: if any isolated act done by any single member charged as a conspirator is prima facie proof that the individual is a conspirator, why, we might just as well wipe out of the books the rules of evidence, and I know of no armor plate which anyone can wear to protect himself securely against being charged with being a conspirator. Now, let us come down to the entire case, including all of these defendants whose names have not yet been brought individually to the attention of the Court. I am going into the corporate defendant for a moment. Let us take the Washington Academy of Surgeons. What proof is there in this case that the Washington Academy ever joined in the conspiracy whatsoever? There is proof here that the Washington Academy of Surgeons had referred to it for its report the question of Dr. Selders' qualifications, and

they recommended back that Dr. Selders didn't have the qualifications which would warrant his admission to the staff of the hospitals which had made the request for the information. That is all there is. That leaves the record in this shape: if they wish us to guess then our guess is as good as theirs as to why Dr. Selders didn't have the qualifications, and if it is to be made a guess then the guess which is based on the common experience of mankind with respect to responsible individuals charged with the performance of a duty must prevail.

I don't know on what theory the prosecution can move this Court to think that every motion which is made by any human being which came in contact with G. H. A. transformed that individual from the honest, upright, reputable citizen, which he has always been, into a base conspirator to accomplish the destruction of G. H. A.

Your Honor knows that if the report of the Washington Academy of Surgeons can be considered to have been made with an honest purpose, after investigation made to advise those who have made the inquiry as to the doctor's qualifications, that interpretation must, under the law, be adopted. We do not have to go further than a case which was tried here in our own Court, in which Justice Letts had before him the same question which I am presenting to your Honor now and which he disposed of on a motion for a directed verdict. It is only a few paragraphs, if your Honor please. It is the case of *U. S.* v. *Drivers, Chauffeurs and Helpers, Local 639, of the International Brotherhood of Teamsters, Drivers, Stablemen and Helpers of America.* He said this:

"It would be impossible for me in a few words to review the evidence in this case, or to announce any conclusions on the many questions of law that have been presented in argument of counsel, or to deal with the construction of these various acts which have been read.

"I have approached this matter from what I thought to be the fundamental ground, indeed an elementary ground, and have searched the evidence to determine whether or not the Government has shown criminal purpose.

"I realize that intent, being a condition of the mind, is not always, perhaps seldom, susceptible of direct and positive proof. It is a matter of inference from facts and circumstances appearing in the evidence. The inferences, I think, lack the inference that arises from circumstances in the consideration of criminal procedure, but not only indicates guilt but it might be inconsistent with any rational theory of innocence."

Now, that is the burden this prosecution has sustained in the interpretation of the evidence presented to your Honor, as prima facie proof of guilt. It must be rationally inconsistent with innocence.

"Here, of course, the intention sought to be shown is that the defendants entered into an unlawful plan to interfere with commerce and trade. We are not dealing with the subject as we would if it were an action for injunction, where only civil rights are involved; but here we are dealing with criminal elements. It seems to me that the evidence clearly shows that all these defendants did is just as consistent with innocence as with guilt, and in order to send this case to the jury, it would be necessary for me to find, in finding a prima facie case, that the evidence did preponderate at least in favor of the Government theory.

"I am of the impression—"

And then the Court proceeds to examine a piece of evidence that came in:

"I think we might determine the purpose and intention which underlay the conduct in the light of what had been barred with respect to this jurisdictional question, and the knowledge which the defendant had of the outcome of it.

"Therefore, all told, I am of the opinion that the Government has failed to make out a case by the substantial evidence which would justify this court in allowing a verdict to stand upon it. According I will call the jury and sustain the motion of the defendants to direct the verdict."

Now then, isn't it just as consistent with the theory of innocence on the part of the Academy of Surgeons to say that those men who are listed—the finest surgeons in the District of Columbia; every doctor who practices surgery generally is on it—to say that they acted innocently rather than to sweep that aside, and with reference to this prosecution, and for its purposes say that every last one of them has suddenly transformed himself into an individual who would stoop to disqualify a qualified surgeon solely in pursuance of this conspiracy? I think, if your Honor please, to have charged the Academy of Surgeons in this case is an insult. I think it is groundless and baseless, on the evidence; and I think it is an attempt to smear these individuals so that perhaps by that smear the Court will weigh the evidence through that dark smear cast upon them instead of the law.

There isn't a single thing against this Academy of Surgeons as a separate organization of individuals which justifies the inference that at any time they had knowledge of this conspiracy or that they knowingly and intentionally did what they did—and they did nothing but make an investigation of a man whom the prosecution has not dared to put on the stand—with any legal intent or purpose.

HARRIS COUNTY MEDICAL SOCIETY

Now then, let us come to the Harris County Medical Society. That is all made out by and through correspondence, once more; inquiries back and forth. Now, I take it, if your Honor please, that if this Harris County Medical Society had a right to do what it did, then it could do what it did under the law, and unless they can show that that act was done intentionally and purposely in furtherance of a conspiracy, which was illegal in scope, then the Harris County Medical Society had a right to do just what it did do. Now, the Harris County Medical Society had a right to write to the District Medical Society in Washington in order to obtain information about one of its members, and the District Medical Society had a right to write to the Harris County Medical Society. If this were a suit for libel, qualified privilege would lie.

Now, we find correspondence back and forth, and we find an investigation being made into the Harris County situation with reference to Selders joining in the work which they considered to be unethical. If it is unethical then they had a right to discipline any one of their members and if such disciplinary action was not done in the furtherance of a conspiracy, then they had the right to do everything which they did, and they finally did nothing. That is the amazing thing in the case. They write, after their examination, as to whether or not they can do anything; they write to the American Medical Association; and there is correspondence back and forth, and finally neither side takes jurisdiction with reference to Selders, and Dr. Selders was never disturbed. Now, here is what they are charged with: they are charged with having done nothing save make an honest investigation to see whether they can do anything, and they are finally advised they cannot, and dropped the proceedings.

Therefore, they are charged here because they made an investigation and after that investigation, upon being advised by one of their memberrs, they decided nothing could be done. Now, because people study as to what to do, write letters, chat about it; therefore they have joined a conspiracy to accomplish the purposes as charged in this indictment. I submit that first of all the very essence is a combination, an agreement and breathing together, a meeting of the minds, on a common purpose; and if you analyze this testimony you will find a floundering around. What they did was to try to determine whether they could do anything. There was no agreement at all; one saying one thing and another another thing. Now they ask your Honor to, because John Brown expresses one opinion, and John Smith says, "No," to hold one. Which one? Are we to be bound by John Brown because the prosecution asks that, or is it John Smith; or does it come once more to this: that under the law after all in a meeting of a society members thereof have the right to express their views and the membership is bound only by the act of the society as a society, and what was said by members in a meeting is not binding upon the membership as a whole, until it is reduced to the action of the society.

AMERICAN MEDICAL ASSOCIATION

Now, if your Honor please, I want to seriously bring to the Court's attention the evidence against the American Medical Association. I presume there were 225 to 250 documents introduced in this case against the American Medical Association, and the individual defendants, officers thereof.

We said we have documents, perhaps some sixty to eighty, which were signed by Dr. West. We have some fifteen or twenty signed by members of the Dr. Leland Bureau. We find an examination made of the Washington hospitals in which on the report thereof to the hospitals is attached the so-called Mundt resolution, but I say this to your Honor and I think it is a fair presentation of the evidence: 90 per cent of that testimony was introduced on the background theory; these resolutions about which your Honor just heard this morning. They are all reports to the house of delegates made by the various bureaus of the American Medical Association to the house, or by the committees referred to, resulting in the adoption by the house of delegates. They are all back in 1934, 1935, and 1936. Now, certainly we are not going to be charged with a conspiracy entered into Jan. 1, 1937, and in doing acts in furtherance of that conspiracy at a time when Group Health was not even organized; and, remember this, your Honor, the American Medical Association had the undoubted right to do every single act which it is charged was done in those years.

Section 3 of the Anti-trust Act has no jurisdiction outside of the District of Columbia, and when the American Medical Association met in its House of Delegates and adopted resolutions, it was doing what it had a right to do. Every letter which was written was written in accordance with that right, which it had the right to do. And the American Medical Association cannot be dragged by the hind legs into this case unless you find that the American Medical Association, as such a distinct corporate entity, bound itself by some corporate act to get into this conspiracy.

Now, what do we find?

Ninety per cent, as I have said to your Honor, was on this background of this conspiracy which your Honor admitted on the theory it established some prima facie proof. Therefore ninety per cent of this evidence has nothing whatsoever to do with the conspiracy itself.

Now, then, we have a meeting on November 6 in Chicago between two members of the District Medical Society, Dr. Hooe and Dr. McGovern, who had gone out to Chicago for advice in connection with the G. H. A. matter, upon the resolution which I advised your Honor some time ago was introduced by Dr. Stanton. We have the article of October 2 in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Now, those two pieces of evidence, outside of some letters which were written, to the effect that we have opposed G. H. A., and statements made, such as "We have opposed G. H. A.," are the only evidence in this case against the American Medical Association.

Now, remembering again, that the American Medical Association has the right to do in forty-eight states of the United States, just what it did, it had the right to write the article it did, and distribute it in forty-eight states of the United States, it had the right everywhere in this country, I mean, in the continental United States, except the District of Columbia, to do what it pleased so far as the Anti-trust Act was concerned, excepting only in the District of Columbia under Section 3.

Therefore, your Honor ought to find that unless, beyond a reasonable doubt, there is evidence in this case prima facie to hold the American Medical Association in it, that it ought not to be dragged into it.

In other words, in deciding that question you cannot give to the statements made and the acts done by the American Medical Association the same quantum of evil interpretation which the prosecution argues as to all for the reason that with respect to all of it they had this undoubted right to do what they did.

Now, what was done?

Dr. Woodward wrote an article, and he wrote that article in October 1937. We have this meeting on Nov. 6, 1937. You will find that the sum and substance of the meeting in November 1937 in Chicago was "go back and employ attorneys and act on legal advice." Now, that is everything there is, I say.

They say "Ah, but the two met."

Suppose they did!

The evidence is that the District Medical Society is a constituent member of the American Medical Association. What is more natural than that a constituent association would go to seek the advice of the national officers who have had the broader experience of having filtered into them the problems from the entire United States?

Now, then, is that evidence, if your Honor please, that the American Medical Association joined a conspiracy in November, November the 6th, that is, after the publication of this article? Remember that the argument is made, and it was made to your Honor before all this evidence was in, it was made that that article was one of the worst conditions in the conspiracy that could possibly be shown. And yet we have, a month later, Dr. Woodward sitting in that same conference with Dr. West, and what came out of it? These conspirators seeking the end and object and purpose of this conspiracy as outlined in this indictment?

What did they say? "Go back and hire a lawyer and follow his advice."

I submit, we cannot make out this evidence, or torture into it some claim that the American Medical Association, as an association, has joined this conspiracy when the last act we have of this American Medical Association is that act where on November 6 they told the representatives of the District Medical Society to go back to Washington and employ counsel.

And I still wish to bring to your Honor's attention the fact that Dr. Woodward in the publication of that article had the right to publish it. He didn't have the right to publish it in the sense I have just discussed it, your Honor, but he had the constitutional right to do it. And before they can construe that as an act done in connection with a conspirator, they must first find that Dr. Woodward knew about this conspiracy.

Now, what did Dr. Woodward know? Your Honor recalls the testimony. He came down here early in June, just before the convention at Atlantic City of the American Medical Association. Dr. Zimmerman testified to the time. He came down here and he tried to get some information about the G. H. A. and he couldn't. They told him nothing. And he went down to the convention, returned, and in October he writes an article setting forth his views with reference to G. H. A. which are based upon, as is shown in the article itself, absolute statutory proof, the proof of the articles of incorporation; and he as a responsible official writes what his views are with reference to G. H. A., in a medical association journal whose circulation is among doctors, to advise the profession of what his views are with reference to the G. H. A. Does that mean that the American Medical Association joined the conspiracy by that act? Are they arguing that the American Medical Association committed that act in furtherance of a conspiracy?

If your Honor please, and I want to insist upon that point, you cannot piecemeal this conspiracy. This conspiracy if it is a picture puzzle, has been put together; and when you want to hold a conspirator or one party in, you cannot take something out of the picture puzzle and say here it is. That doesn't make the conspiracy. This conspiracy is *one*—nothing else! They have detailed the three manners, the three ways, in which this conspiracy is supposed to be accomplished; By the denial of the right of consultation; by the refusal of admission to hospitals; and by the difficulty thrown in the way of G. H. A. on membership in staffs, both their own staffs and the staffs of hospitals. On October 2 there hadn't anything developed. Everything that happened happened after Dr. Woodward wrote his article. Nothing was done with respect to anything up to October 2 except they start pulling out these statements made in the minutes of meetings of the District Medical Society. That doesn't bring home the knowledge of a single one of them to anybody in connection with the American Medical Association; and they didn't bring the knowledge of the American Medical Association as such. Now, merely bringing the knowledge of something done to a single individual of the American Medical Association does not bring responsibility on the American Medical Association as such, an independent corporate entity, if the Court please.

Now, what else do we find besides the article and the meeting of November 6? This is a conspiracy, if your Honor please. Let us examine it coolly and calmly in the light of what the law says. Woodward is called by the Medical Society in November 1938. Here is the conspirator. Here is the man who is so evil and vile a conspirator that he has written this terrible article about which there cannot be a possibility of justification. And when he goes to the society he is called upon to make a talk at the meeting. G. H. A. is being discussed. The prosecution is saying that G. H. A. was the subject of destruction in that meeting. If there was any way they could pronounce its death knell, they wanted to do so. And here is the arch conspirator, the man who spread all over and through the United States this destructive article. It didn't go through the United States. It went to its members. It is a medical journal. It isn't a funny sheet. Woodward stands up in that meeting, as late as November, and counsels them to get counsel and to be advised by their counsel. Now, it is an easy thing to charge all these people in this gigantic conspiracy. It is an easy thing to evolve a theory in one's mind when sitting calmly down at a table.

It is an easy thing to hurl at the faces of those others the vilest of imputations which motivates such conduct, but when you come to prove it calmly, when we come to examine the proof after it has been introduced, and when we come to say "Let us wait just a minute. Let us see if this particular individual is the kind of individual to do the things you say about him. Or let us see if after all, he isn't a man just as you and I, entitled to your likes and dislikes, entitled to act in accordance with his likes and dislikes just so long as he doesn't impinge illegally upon the rights of another so to do."

And we find right here that this worst of conspirators, if your Honor please, having written an article on October 2, on November 6 counsels legal advice for the members of the District Medical Society and then in conjunction with that when he is in Washington and invited to say a word at the District Medical Society he renews that advice.

And does that sound like a conspirator acting in furtherance of a conspiracy? Or does it sound like the attempt of a pleader to drag by the heels into an indictment the names of men who should not be entered as conspirators and men who in no wise bound the American Medical Association?

You remember when Laux was on the stand. I asked him whether or not he had any right, or his bureau had any right to fix the policy of the American Medical Association. And

what was his reply? "The policies of the American Medical Association and the acts which bind the American Medical Association appear in the action of the House of Delegates, or of those done by the Board of Trustees within the jurisdiction allotted to them under the constitution." There isn't a single act in a single House of Delegates report which binds the American Medical Association with respect to a single thing on G. H. A. They quit in 1936. They go back to 1931, in one instance. And all of that evidence your Honor let in under the background theory. Ninety per cent of the evidence in here is on the background theory. "Ah," but they say "we have Dr. West. Now we switch from Woodward over to West as the arch conspirator."

Dr. West was the general manager of the American Medical Association and in three or four letters and in the conference of Nov. 6, 1937 in Chicago he said "We have opposed G. H. A." I am going to ask your Honor to think of the situation in the Apex case. I wonder what this prosecution would do if they had the evidence which the prosecution had in the Apex case. I wonder if they have in this case now the proof that these doctors went down and sat down in the G. H. A. clinic. I wonder if they could have the evidence or what they would say about it if they had it, that the American Medical Association sent a crowd down there and said "We camp right here in your clinic. We are going to break up your X-ray apparatus. We are going to see to it that you don't allow anybody in here. We are going to prevent everything that is done in this clinic." That is what they did in the Apex case with reference to the hosiery factory. We didn't do that. They assaulted, they committed crimes, they broke up the necessary machinery, they prevented hundreds of thousands of pairs of hosiery being sent out in interstate commerce. I wonder if the prosecution in this case had that kind of proof what they would be saying to this jury.

And what did the Supreme Court say about it? The Supreme Court said "Unless those acts were done with an intent to interfere with interstate commerce, there is no jurisdiction to proceed under the Sherman Anti-trust Act. And if those men did what they did not with an intent to interfere with interstate commerce, we don't care what their intentions may have been so long as the evidence does not show their intent was to restrain interstate commerce." The Court had no jurisdiction to proceed. And yet that case had to go clear to the Supreme Court to decide what everybody knows, outside of the heat of a trial, what common sense tells us. In this case you cannot tell me where anything Dr. West wrote is anything more than the truth. Has Dr. West no longer the right to be opposed to anything except what the prosecution wants or likes? What has Dr. West done in the evidence to oppose G. H. A.? Point to a single act. Show me a single thing Dr. West has done which shows an intent to restrain trade in the District of Columbia. If your Honor please, in the face of cases which the Supreme Court has dealt with, take the last case, if your Honor please, which the Court had before it, the case on the jurisdictional dispute, just what this dispute is if you want to make it that—they are making it a dispute in this case between the—I don't know the phrase they wish to place upon it—payment for service as against prepayment on a cost basis.

There is a dispute that existed. Have you found a single act done, if your Honor please, tending toward the restraint of trade in the District of Columbia? Except acts which they must interpret to be such. Can you point to a single positive act done by a single defendant in this case which tends to restrain trade in the District of Columbia? Every single act which any one of these defendants has been charged with doing requires for its completion the independent act or conduct of a stranger or a third person. The restraint of hospitals is predicated upon the December 1 resolution. That December 1 resolution is not self executing. It depends for its effectiveness, if at all, upon the independent action of third persons, to wit, hospitals. And those hospitals may do or may not do anything they choose about that December 1 resolution. Is there a single threat in this case that they would do anything to a hospital if the December 1 resolution was not complied with. But the prosecution say "Oh, we must guess there was." No, we don't. We don't guess in criminal cases. We prove.

Now, then, where do you find, if your Honor please, anything that compares to what was shown in the direct proof in such cases as the Hutcheson case or in the Apex case? In the Hutcheson case where they sat down there and just prevented interstate traffic moving; they had their little jurisdictional disputes among themselves, but they pushed it to the extent that they would not permit the interstate traffic in the transportation or shipment of beer. Where do you find anything like that in this case?

Let us get down to the reasoning which the Supreme Court has approved. And if your Honor please, I want to press firmly upon the Court at this time that if we are a trade organization, if we are engaged in trade, it doesn't matter so far as the Sherman Anti-trust Act is concerned and the Clayton Act, or the Norris-LaGuardia Act whether you pin the label on this side "labor organization" or whether I pin the label on this side "trade organization." We are engaged in trade. Our trade is the performance of our service, for a price. That is what they have stigmatized it. They have brought it out of the dignity of a profession down to the commercial plane of trade, sale and barter of medical care for a price. That is our business. We are engaged in trade. The Court of Appeals said so. All right then, if we are tradesmen, we have the right of tradesmen, and they cannot push us into an indictment upon one theory and say they hold us out of it upon another.

They cannot say we have violated the law, the anti-trust law, with the one hand, when they know they can produce from the files the other which says that under that theory you certainly have certain protection. The Clayton Act did it and under the Hutcheson case the Norris-LaGuardia Act says that in a dispute or controversy of this kind they cannot move against us. Now, let us have no doubt of that, if your Honor please. I have here this Hutcheson case and also the pronouncement of the Supreme Court.

Mr. Lewin:—Are you making this argument seriously?

Mr. Leahy:—You bet I am. Don't think I am standing here exercising my lungs.

Mr. Lewin:—I was afraid you were.

Mr. Leahy:—You are afraid of a lot of things that you don't know yet.

Let me give this to your Honor. He says, if your Honor please, am I making this seriously.

I am not going to read to your Honor the Clayton Act. Your Honor knows what that says. This is the LaGuardia Act:

"No restraining order or injunction shall be granted by any court of the United States, or a judge or the judges thereof, in any case between an employer and employees, or between employers and employees, or between employees, or between persons employed and persons seeking employment, involving, or growing out of, a dispute concerning terms or conditions of employment, unless necessary to prevent irreparable injury to property, or to a property right."

"and no such restraining order or injunction shall prohibit any person or persons, whether singly or in concert, from terminating any relation of employment, or from ceasing to perform any work or labor, or from recommending, advising or persuading others by peaceful means so to do; or from attending at any place where any such person or persons may lawfully be, for the purpose of peacefully obtaining or communicating information, or from peacefully persuading any person to work or to abstain from working; or from ceasing to patronize,"

and so forth.

"Whereas under prevailing economic conditions, developed with the aid of governmental authority for owners of property to organize in the corporate and other forms of ownership association, the individual unorganized worker is commonly helpless to exercise actual liberty of contract and to protect his freedom of labor, and thereby to obtain acceptable terms and conditions of employment, wherefore, though he should be free to decline to associate with his fellows, it is necessary, that he have full freedom of association, self organization, and designation of representatives of his own choosing, to negotiate the terms and conditions of his employment, and that he shall be free from the interference, restraint, or coercion of employers of labor, or their agents, in the designation of such representatives or in self organization or in other concerted activities."

Now, with reference to that, here is what the Court says:

"Were then the acts charged against the defendants prohibited or permitted by these three interlacing statutes?"

That is the Sherman Antitrust Act, the Clayton Act and the LaGuardia Act.

"If the facts laid in the indictment come within the conduct enumerated in Section 20 of the Clayton Act they do not constitute a crime within the general terms of the Sherman Law because of the explicit command of that section that such conduct shall not be 'considered or held to be violations of any law of the United States.'"

Now, if your Honor please, that phrase, the phrase "labor organization which is organized not for profit"—we have here a trade organization organized not for profit.

Now, if they say that it is a wide stretch to appeal to the Clayton Act in this particular, I say it is no wider stretch than they made when they appealed to the Sherman Act to make us a trade organization.

Mr. Lewin:—You mean when the Court of Appeals said it.

Mr. Leahy:—I meant you made it.

Now, if we are a trade organization, we are a trade organization. Now, he seems to say "Oh, well, you aren't a labor organization." Well, what are we? Our service is labor.

They so state it. They have offered evidence in here of the hospitals. Because the hospital report of the Emergency Hospital says that the business done shows it is one of the big business organizations of the District of Columbia. In other words, we are all in trade.

But you cannot separate the difference. The Court of Appeals has said we frequently call a bricklayer or a bootmaker a trade. And there is no doubt in the common law all the way down, trades or engaged in trade. It doesn't make any difference so far as the protection of the law is concerned.

If the Sherman Law says you can do it to the bricklayer or the paperhanger or the painter, and now the Court of Appeals has said that trade is so broad as to include the practice of medicine, then I say, your Honor, we have a right to protection under the Clayton Act.

Now, what does it say?

Remember, the hospitals are just as much engaged in trade. Here are three groups all engaged in the conspiracy.

"So long as a union acts in its self-interest and does not combine with non-labor groups, the licit and the illicit under Section 20 are not to be distinguished by any judgment regarding the wisdom or unwisdom, the rightness or wrongness, the selfishness or unselfishness of the end of which the particular union activities are the means."

Now, if your Honor please, so long as a union acts, a union is a trade association. That is all it is. A trade organization.

So long as a trade organization acts in its self-interest—and that is all that was done here under any charge—and does not combine with non-trade organization groups, the licit and the illicit under Section 20 are not to be distinguished by any judgment regarding the wisdom or unwisdom, the rightness or wrongness, the selfishness or unselfishness of the end of which the particular union activities are the means.

Now, I say if we are what they have pronounced us to be, if we are this trade organization, if the word "trade" means what the Court of Appeals has said it means, and if all it means is that actually we are just simply a labor organization—because that is all we do—we aren't engaged in any other activity, it is a nonprofit organization—and I say that you cannot stretch the law in order to strike us on the rebound and deny us the defense of the law to which we are entitled against attack.

The Court just went further in another decision involving a milk dispute between producers and the union, the drivers; out in Chicago.

What did the Court do there? It protected a milkman. Perhaps we aren't as high as a milkman. Perhaps the doctor ought not to receive quite so much protection under the law as the man who milks cows. Perhaps the dairyman engaged in trade is engaged in a trade which they will gladly give the protection of the law to. They didn't, even there. But the Supreme Court said they must.

Now, if the producer of milk, the ordinary dairy, is entitled to the protection of the Norris-LaGuardia Act, all three acts placed together, the trilogy of them, and if the Court of Appeals upon their urgency his pronounced that we are tradesmen, then upon what theory does this stretch of the imagination of the prosecution bring us to the point that it is out of the question that we should have any protection under the law? We are out in a plain or an island of utter abandonment where we have no rights left except to do the best we can where they hurl these charges against us.

I submit upon that theory as the case now stands they have proved it. They have proved us to be tradesmen. They have introduced evidence here before this jury that hospitals are nothing more than trade institutions; trade institutions for one purpose it was brought out, that is, for the care of the sick. And we think we have the right to the protection of a trade organization which the Clayton Act and the Norris-LaGuardia Act give to us.

I have already talked longer than I expected, if your Honor please, on this argument. But I say there has been no proof whatsoever here that the American Medical Association is in any way joined in the conspiracy. The only acts which they have brought forth as the acts of the American Medical Association relate only to the background theory. The acts which they have brought forward are so nullified by other acts which they find, for instance, with reference to the defendantWoodward, with reference to the defendant West—there is nothing which he did, absolutely nothing is shown which he did. He said, "We have opposed it." They have a right to oppose it, if your Honor please. The mere stating of opposition is not stating with the knowledge of a conspiracy which not yet had ever been formed according to the theory of the prosecution. And when we come down and in the same sort of analysis of the testimony in this case, we find that not an act is urged against Leland. Well, how is he responsible here? What has he done? Every single letter relates to the background of the conspiracy. Because someone writes him a letter and he answers back:

"I have just been advised that the Comptroller General has declared the H. O. L. C. loan illegal,"—

probably it was published in the newspapers. He states some friend advised him of it. Can he be held as a conspirator with a knowledge of this?

Take Dr. Fishbein. Not a thing against him. But they ask your Honor to hold individually these members for a full knowledge of this conspiracy or for joint acts of their own with others in the performance of acts in the furtherance of this conspiracy. Now, simply because Dr. Fishbein happened to be the editor of the American Medical Association, Dr. Woodward was the head of another bureau, and Dr. West was the general manager, I submit there is no law which can be appealed to to state there was any conspiracy in this case such as is outlined in the indictment, and such as these defendants should be held in as prima facie defendants.

And for that reason, if your Honor please, we ask for a directed verdict, particularly with reference to those particular defendants whom I have mentioned; generally one and all of them; more particularly, as we have just stated, with reference to the individuals corporate and associated defendants, and in a group as to each and all.

And if your Honor please, we have prepared here the formal motions with reference to certain allegations in this indictment which I should like to file and present the other side without going over, to take up the Court's time further with them but will hand them to counsel.

There is a copy attached to each, and we will distribute them to the prosecution.

(The motions referred to are as follows:)

IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, Plaintiff,
vs.
AMERICAN MEDICAL ASSOCIATION, et al., Defendants. No. 63,221

MOTION OF DEFENDANTS FOR A DIRECTED VERDICT

Come now the defendants American Medical Association, The Medical Society of the District of Columbia, Harris County Medical Society, Washington Academy of Surgeons, Arthur Carlisle Christie, Coursen Baxter Conklin, James Bayard Gregg Custis, William Dick Cutter, Morris Fishbein, Robert Arthur Hooe, Roscoe Genung Leland, Leon Alphonse Martel, Thomas Ernest Mattingly, Francis Xavier McGovern, Thomas Edwin Neill, Edward Hiram Reede, William Mercer Sprigg, William Joseph Stanton, John Ogle Warfield Jr., Olin West, William Creighton Woodward, Wallace Mason Yater, Joseph Rogers Young and Prentiss Willson, by their attorneys and move the Court to direct the jury in the above entitled cause to return a verdict of not guilty as to each and all of the aforesaid defendants.

And for cause therefor defendants state that no sufficient case has been made out against them and each of them under the indictment herein returned, to warrant and support a verdict on all or any of the charges alleged in said indictment.

Edward M. Burke,
William E. Leahy,
Seth W. Richardson,
Charles S. Baker,
Warren E. Magee,
John E. Laskey,
Attorneys for Defendants.

Similar motions were introduced covering the charges of restraint of Group Health Assn., Inc., restraint of its members, restraint of its doctors, restraint of other doctors, restraint of the Washington hospitals.

MARCH 6—AFTER RECESS

ARGUMENT ON BEHALF OF THE UNITED STATES IN OPPOSITION TO MOTION FOR A DIRECTED VERDICT

JOHN H. LEWIN

Mr. Lewin:—May it please the court, I take it that the purpose of any argument of this kind is to assist the court in arriving at conclusions, and I will try to bear that in mind in making my remarks. I certainly do not believe that it could help the court in any way for me to reargue the demurrer which was argued before your Honor for about a day, I believe, and then reargued in the Court of Appeals and decided. I do not think it could help the court for me to even dignify with an answer any far-fetched contention that the specific statutory exemption of labor unions in certain situations set forth in

the Clayton Act and with regard to procedure under the Norris-LaGuardia Act, would have any possible application here. And unless the court wants to hear me on an issue like that, I am not going to argue that.

THE COURT:—I am inclined to think that I am bound by the ruling of the Court of Appeals.

Mr. Levin:—Yes. I do think that I might assist your Honor in calling the court's attention to an extremely pertinent decision, an extremely recent decision, from the highest legal authority of the land, the Supreme Court of the United States, which was handed down on Monday last, and which corroborates and sanctions and affirms the soundness of the Court of Appeals' decision in this case and clarifies the issues that are before your Honor.

That case is entitled *Fashion Originators' Guild of America, Inc.*, v. *Federal Trade Commission*, and the opinion in the case is by Mr. Justice Black, and he speaks for a unanimous court. The case was decided March 3, 1941.

Now, there are some superficial differences between that case and this, and I want now to concede them.

The victims in that case, the people whose activities were restrained, were not medical cooperatives seeking to distribute services of that character to hospitals or doctors pursuing the economic side of their calling and gathering in their fees. But I take it that the fact that the victims in that case were manufacturers of ladies' dresses makes no difference here if we admit that the Court of Appeals has once and for all determined for the purposes of this case that the Sherman Act, Section 3, applies to restraint upon the activities of the victims in this case; but I must allude to it because I think that maybe we will save time if I do it.

It is true that the victims of the conspiracy were doing different things. Now, what did the actors do in the Fashion Originators' Guild case? They did things very similar to the things which the evidence in this case overwhelmingly establishes that the defendants indulged in. And to make good on that point, let me read to your Honor what the court said on that:

"Some of the members of the combination design, manufacture, sell and distribute women's garments—chiefly dresses. Others are manufacturers, converters or dyers of textiles from which these garments are made. Fashion Originators' Guild of America (FOGA), an organization controlled by these groups, is the instrument through which petitioners work to accomplish the purposes condemned by the Commission."

That is, the Federal Trade Commission. The case came up from the Federal Trade Commission.

"The garment manufacturers claim to be creators of original and distinctive designs of fashionable clothes for women, and the textile manufacturers claim to be creators of similar original fabric designs. After these designs enter the channels of trade, other manufacturers systematically make and sell copies of them, the copies usually selling at prices lower than the garments copied. Petitioners call this practice of copying unethical and immoral,"—

I pause to ask if that has not a familiar ring in this case. You find it in every Sherman Act case including the case at bar. The way to reach your victim in a sanctimonious way is to use this term "unethical." Here they were a little more honest than the defendants in the case at bar, because they added to it the claim that these people were immoral. So they were unethical in the sense that they were doing something which the petitioners did not like in competition with them, and the claim is also that they were immoral, and they "give it the name of 'style piracy.'

"and although they admit that their 'original creations' are neither copyrighted nor patented, and indeed assert that existing legislation affords them no protection against copyists, they nevertheless urge that sale of copied designs constitutes an unfair trade practice and a tortious invasion of their rights. Because of these alleged wrongs, petitioners, while continuing to compete with one another in many respects,"—

as in the case at bar—"combined among themselves to combat"—

Has that a familiar ring in this case? You remember in my reading of the minutes how on every page there was some plan offered by one of these defendants and the co-conspirators to combat.

"and, if possible, destroy all competition from the sale of garments which are copies of their 'original creations.' They admit that to destroy such competition they have in combination purposely boycotted and declined to sell their products to retailers who follow a policy of selling garments copied by other manufacturers from designs put out by Guild members."

They are simply going to withhold their trade. None of the members of our little group are going to have anything to do with these people whom they brand as unethical, or will not serve on their staffs, and they say, "We will not consult with them. We won't even let them use our hospitals"—which their resolution says the defendants have built up, although they are private concerns.

"As a result of their efforts, approximately 12,000 retailers throughout the country have signed agreements to 'cooperate' "—

I ask if that has a familiar ring. In getting the hospitals to cooperate, formal resolutions were passed in this case designed for that very objective

"with the Guild's boycott program, but more than half of these signed the agreements only because constrained by threats that Guild members would not sell to retailers who failed to yield to their demands"—

Oh, how similar to the overwhelming evidence here! What does the court do with that sort of situation, which is a plain, ordinary selfish boycott? We don't like you. We don't like your business methods. Your competition hurts us. We will therefore take a sanctimonious Better Than Thou attitude and brand you as unethical, and we will employ this agency to discipline our members to boycott you, and we won't deal with you or sell, assist, or lend our countenance in any way to anybody who does deal with you.

This is what the court says about that

"Not only does the plan in the respects above discussed thus conflict with the principles of the Clayton Act; the findings of the Commission bring petitioners' combination in its entirety well within the inhibition of the policies declared by the Sherman Act itself. Section 1 of that Act makes illegal every contract, combination or conspiracy in restraint of trade or commerce among the several states; Section 2 makes illegal every combination or conspiracy which monopolizes or attempts to monopolize any part of that trade or commerce. Under the Sherman Act 'competition not combination, should be the law of trade.' "

Citing the National Cotton Oil Case—

"And among the many respects in which the Guild's plan runs contrary to the policy of the Sherman Act are these: it narrows the outlets to which garment and textile manufacturers can sell and the sources from which retailers can buy"—

Citing the Montague case and the Standard Sanitary Manufacturing Company case—

"subjects all retailers and manufacturers who decline to comply with the Guild's program to an organized boycott"—

What does the court cite? The very thing that Judge Groner cited in upholding the indictment in this case—the Eastern States Retail Lumber Dealers' Association against the United States, the famous White List case—

"takes away the freedom of action of members by requiring each to reveal to the Guild the intimate details of their individual affairs"—

Citing the case of the United States versus American Linseed Oil Company—

"and has both as its necessary tendency and as its purpose and effect the direct suppression of competition from the sale of unregistered textiles and copied designs. In addition to all this, the combination is in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations,"—

Such tribunals, if you please, presided over by private individuals, like the defendant E. Hiram Reede, and a private tribunal known as the Judicial Council, a private corporation of A. M. A. which passes on a man's right to live and move and have his being and make a living and pursue his calling— "for determination and punishment of violations, and thus 'trenches upon the power of the national legislature and violates the statute.' "

How close that is to the issues in this case. That is all they were doing—punishing infractions of their rules. And this is the position of the Government in this case and it always has been

"Nor is it determinative in considering the policy of the Sherman Act that petitioners may not yet have achieved a complete monopoly. For 'it is sufficient if it really tends to that end and to deprive the public of the advantages which flow from free competition.' "

Citing a host of cases—

"But petitioners further argue that their boycott and restraint of interstate trade is not within the ban of the policies of the Sherman and Clayton Acts because 'the practices of FOGA were reasonable and necessary to protect the manufacturer, laborer, retailer and consumer against the devastating evils growing from the pirating of original designs and had in fact benefited all four.' The Commission declined to hear much of the evidence that petitioners desired to offer on this subject. As we have pointed out, however, the aim of petitioners' combination was the intentional destruction of one type of manufacture and sale which competed with Guild members. The purpose and object of this combination, its potential power, its tendency to monopoly, the coercion it could and did practice upon a rival method of competition, all brought it within the

policy of the prohibition declared by the Sherman and Clayton acts. For this reason, the principles announced in *Appalachian Coals, Inc.*, v. *United States* . . . have no application here."

Just apply that language to our case—

"the aim of petitioners' combination"—

And they wrote it themselves over and over again—

"its potential power"—

Can anybody doubt it?

"its tendency to monopoly, the coercion it could and did practice upon a rival method of competition"—

It did what?

"brought it within the policy of the prohibition declared by the Sherman and Clayton Acts."

"Under these circumstances it was not error to refuse to hear evidence, for the reasonableness of the methods pursued by the combination to accomplish its unlawful object is no more material than would be the reasonableness of the prices fixed by unlawful combination."

Once you have that type of boycott described there—and that description is on all fours with the type that we have here, or, if anything, ours is worse—then it is not error to refuse to hear evidence on any claim of reasonableness of their motives or methods, and it is

"no more material than would be the reasonableness of the prices fixed by unlawful combination."

And the court cites the Trenton Potteries Company case and the Socony-Vacuum Oil Company case in support of that proposition.

Here is an interesting feature, too:

"Nor can the unlawful combination be justified upon the argument that systematic copying of dress designs is itself tortious, or should now be declared so by us."

Here was this absolutely groundless claim that Group Health Association was illegal and was violating Federal statutes.

"In the first place, whether or not given conduct is tortious is a question of state law. . . . In the second place, even if copying were an acknowledged tort under the law of every state, that situation would not justify petitioners in combining together to regulate and restrain interstate commerce in violation of Federal law."

If we are going to cite recent cases, it seems to me that is the case that applies to ours, and it bears out exactly the holding, as I understand it, of the Court of Appeals in this case. The Court of Appeals said that the indictment as drawn makes out, in and of itself, a violation of the Sherman law. If the facts establish that, then the defendants may be convicted. That is the only issue here—whether there is sufficient evidence to justify this jury in saying that the boycott described in the indictment was carried out as planned. That is the only issue.

I cannot believe for one moment that it would help the court for me to discuss the evidence against all the defendants in this case. If I do that it is going to take me days. I cannot believe that your Honor can have any doubts about the prima facie evidence against many of the defendants.

Under the evidence before your Honor the boycott described in the indictment was planned and put into effect by somebody; and it must be too clear for argument that it was certainly done by the District Medical Society and the American Medical Association and the rest of the ringleaders, because it must be axiomatic that corporations like the American Medical Association and the District Medical Society cannot perform acts of this kind without the intervention of a human agency. The grand jury has pointed out the ringleaders, the individuals that carried out this boycott for the corporations. So perhaps I ought to dwell on those defendants upon whom Mr. Leahy dwelt.

I will discuss, for instance, as an example, the evidence against Dr. Leland. It is an awfully easy job assigned to me, because Mr. Leahy has laid himself wide open. Without a shadow of justification he says that the only evidence in this case against Leland is composed of letters not written by him, but by some subordinates, and relating to the background of the conspiracy. I propose to demonstrate that that statement is completely inaccurate from the beginning to the end.

But before I embark on that rather agreeable task, let me call your Honor's attention to a little more law, and that law involves these principles:

All members of an illegal conspiracy do not have to know everything about the conspiracy or everything that everybody else has done in the conspiracy. That is also Hornbook law. It is enough if, knowing the general common design, he adds his little bit toward its accomplishment. If he put his brick in the wall he does not have to know the extent of the wall; he does not have to know the extent of the activities of the others or even the names of the others.

Says the Court of Appeals of the Third Circuit:

"Common design is the essence of conspiracy. A crime may be commited whether or not the parties comprehend its entire scope, whether they act separately or together by the same or different means, known or unknown to some of them, but ever leading to the same unlawful result."

Citing cases—

"All conspirators need not be acquainted with one another, nor need they have originally conceived or participated in the conception of the conspiracy. Those who come in later and cooperate in the common effort to obtain the unlawful results become parties thereto and assume responsibility for all done before."

Citing cases—

"Nor does the mere fact that the conspirators individually or in groups perform different tasks to a common end split up the conspiracy into several different conspiracies."

And of course the cases are legion that bear out these principles. And with those principles in mind let us turn to the part which was performed by Dr. Leland and which the evidence shows was performed by him.

First, let me deal with the subject of background. Those allegations of background alleged in the indictment were not put in there for ornament, and the Court of Appeals, in passing upon the indictment, did not take them as ornament. The Court of Appeals commented upon that background and said that those allegations were relevant to the statement of the crime; that they had something to do with the statement of the crime, and that it is only in the light of those facts that you can clearly understand the significance of the later acts.

And so I differ from my friend when he says that the background has nothing to do with the case. The law is against him on that. The background is asserted and is relevant in this case, because it shows the common design, the plan which the American Medical Association was carrying out for years against competition of this kind with a fee-for-service object; and their later activities in the District of Columbia are simply a later step in that complete master design. When they pushed that master design into the District of Columbia then the Federal law fell upon them.

The indictment alleges as a part of this plan and design the power whereby the defendants were able to exercise their will upon their victims here:

"Defendant American Medical Association maintains a bureau known as the Bureau of Medical Economics, which concerns itself with the economic organization of the practice of medicine. The said Bureau of Medical Economics has taken a leading part in carrying out defendant American Medical Association's policy of opposing, discouraging, and suppressing Group medical practice on a risk-sharing prepayment basis."

The evidence shows that the head of that organization which was taking this leading part in the master plan, was a doctor of medicine—yes, a doctor of medicine, and also a doctor of economics, not practicing medicine but practicing birth control—not with human beings but with economic ideas. And this Bureau of Medical Economics was really a birth-control clinic for experimentation and for freedom of thought; and this background evidence which is in the case shows that this doctor-economist had been busily engaged for years in active suppression and opposition against plans of this character. He had been damning the Ross-Loos Clinic and the Trinity Hospital and four or five or six other instances of this kind of practice up and down the land. And, just as typical of what that background evidence against him is, when the Cincinnati, Ohio, Medical Society writes and tells him that a Dr. Cook has gone out to the Ross-Loos Clinic and has become interested in this way of rendering medical service and plans to do the same thing in Ohio and, further, that this group that belonged to the local society had banded together and passed repressive resolutions against him, to the effect—

"Does practice under a prepayment group plan, such as is being here proposed and which does not include all of the local qualified physicians of the community, but restricts itself to a small group, constitute a violation of Article 6, Section 2, of the Principles of Ethics of the American Medical Association?

"Shall membership in the Academy of Medicine of Cincinnati be withheld from physicians who are practicing in violation of this rule?"

He was going to kick them out, just like Lee and Scandiffio.

"Shall violation of this rule by a member of the Academy constitute sufficient reason for termination of his membership?"

There it is again. They were going to have another one of the trials, and they passed these repressive resolutions and sent them to Leland for his information and advice—because they

all go back to this Alma Mater, this American Medical Association, because they are afraid of it and because they are willing to use its power, and so they dutifully write in reporting their restrictive practices.

I say that is typical of this background evidence which the Court of Appeals said was relevant upon the issue of whether or not theses defendants violated the law.

Now, let us come to the District of Columbia Society and reiute right from the documents that are in evidence this claim of Mr. Leahy that there is nothing in the evidence with reference to that.

I wish I had jotted down what he said. He said something to this effect, that the only evidence in the record with regard to Leland is this background material, and not a bit of it had to do with the District of Columbia. I believe at one time, in the heat of his excitement, he said:

"There is no evidence that the defendant Leland knew about the District Medical Society, even."

Well, let us see. Here is Mr. Leahy's statement:

"Every letter relating to Leland relates to the background of the conspiracy. There is nothing against him except answers that were written in the background, and he did not even write them. He does not know, from this record, that there was a District Medical Society. He, just on this record, did not even know of it."

That is the claim that is put forth in seriousness before your Honor by Mr. Leahy.

Let us see what he did in the District of Columbia to carry out this policy that he has been carrying out throughout the United States.

Major General Ireland, your Honor may remember, learned about Group Health and about its perfectly innocent attempt to get a good medical director, Colonel Jones, and General Ireland took upon himself to write to the defendant Cutter and gave him that information and gave him Ireland's impressions of what Jones had said, although Jones denied it. He said that Jones got the impression that this was an entering wedge to socialized medicine, and that he was dropping it like a hot cake. He said,

"Just treat this information as if it blew in your window, as I do not want to be the person to embarrass the Surgeon General if there should be any embarrassment. Some of the prominent doctors in Washington are going to be wised up. It has just come to my knowledge and I am going to drop it on your desk."

That letter goes not only to Cutter, but as result of it he began his enforcing of the Mundt Resolution against five of the hospitals. But it shows on its face that it goes to Dr. Leland. And I don't know where you could find more fertile ground for that seed to rest than in that birth-control clinic of prepayment plans. They think so much of it and it is so important to them, that bit of information, that copies are made of it and we have a separate copy in the evidence that comes from the Leland file, made for him, and it has his name at the top.

Then the American Medical Association gets exercised about it and they have formal proceedings with regard to it, and in their proceedings we find this:

"The following paragraph of a communication which Dr. West received from a physician in Washington was read"—

And they quote it.

"The Group Health service affair of the Home Owners Loan Corporation has already been incorporated and our Executive Committee had a meeting with some of their representatives last night and it certainly looks bad. It was brought out that it was possible for them to borrow money from the Home Owners Loan Corporation when and if necessary at any time for purposes in regard to the health problem. It was also brought out that there are 200 branches scattered throughout the United States," and so forth.

"Just what is going to come out of the whole affair it is impossible to predict at this time, but there are going to be some conferences in an attempt to go along with this outfit if it is possible to do so to save our faces."

Mr. Leahy:—You do not mean to tell the court that that is an A. M. A. document?

Mr. Lewin:—I do indeed.

Mr. Leahy:—You know that was not written by the A. M. A.

Mr. Lewin:—Just wait a minute. I am going to tell the court who wrote. It was written by Dr. Herbst to Dr. West and was put by West before the Board of Trustees of the A. M. A. and copied into their minutes. I don't get funny with this evidence, my friend. I don't misstate evidence. I have never been guilty of it, to my knowledge.

Mr. Leahy:—Just tell the court who wrote it.

Mr. Lewin:—I am going to tell the court plenty about it:

"Dr. Woodward reported information secured from a Washington physician over the telephone and by letter concerning this matter, and there was considerable discussion as to what the action of the A. M. A. should be. . . After the discussion the following action was taken: "Dr. Bloss moved that the Editor"—

That is the defendant Fishbein—

"and the Secretary and General Manager"—

Here is a doctor-editor and a doctor-general manager—

"be authorized to proceed to inform the profession of the country as to the efforts of the H. O. L. C. to enter into the practice of medicine and as to the present status of the proposal to organize cooperatives by the Government."

I will come back to that again, because there is the germ from which came Dr. Woodward's, Dr. West's and Dr. Fishbein's A. M. A. articles which Mr. Leahy says in his argument started everything.

"It was moved, and the motion was seconded by Dr. Bloss and carried, that Drs. Woodward and Leland be requested to go to Washington to see what they can learn and to try to advise the Medical Society of the District of Columbia, if that Society is willing to accept advice."

Oh, no! Leland had nothing to do with the District Medical Society! He knew nothing about it.

Here is a formal resolution of the Board of Trustees authorizing him to go to Washington to advise with the District Medical Society about this particular matter, the matter being outlined in the Herbst letter to the Board of Trustees, which has just been read. Now, what happened? Did he go to Washington pursuant to that authorization? Indeed he did. He came to Washington on several occasions in connection with this matter, as the evidence shows.

"I had a long conference with a committee of the Medical Society of the District of Columbia about the cooperative movement being promoted by groups of Government employees."

This is not the meeting in November where Hooe and McGovern were together at that time. This is another one. This is as early as July 14:

"The District Society is apparently very much agitated about the matter, but, as a matter of fact, there was very little that I could offer them in the way of suggestions as to what they might or should do. In accordance with authorization given by the Board of Trustees I have asked Dr. Woodward and Dr. Leland to go"—

Where?

"to Washington"—

What for?

"for the purpose of conferring with the Medical Society of the District of Columbia, and they are to have a conference with the official representatives of the Society in Washington."

And later I will come to his statement which he made time and time again to the headquarters staff—which means the Doctor-Editor and Doctor-Manager, the Doctor-Lawyer, the Doctor-Economist and the Doctor-Policeman. The headquarters staff had done everything in their power to oppose and combat this organization.

All right. We have got him authorized to go and we have got the Doctor-Manager to go. Did he go? Here is a telegram from the Doctor-Lawyer dated July 13, 1937:

"Leland and I arrived Capitol Limited Wednesday Stop Leave it to your judgment to arrange a conference at which all essential persons will be present Stop It will apparently be necessary for the Society to employ counsel to guide it and presence of that counsel at conference is essential Stop If regular counsel is not available his representative or other counsel should be present Stop Please arrange so that we can leave Washington not later than Thursday afternoon July fifteen Stop Time of conference immaterial to us We shall be at the Mayflower."

That is signed by the defendant Woodward.

That was July 13, 1937. On July 14, 1937 Woodward and Leland were here pursuant to that authority and in conference with the rest of the confederates with regard to suppressing Group Health. How do we know that? This same Dr. Leland who, his counsel tells you in all sincerity, I hope, did not even know there was a District Medical Society, had already received, June 5, 1937, this communication from Dr. Conklin—and will you keep in mind that with this communication he received that mimeographed confidential prospectus. Dr. Conklin wrote him as follows:

"I am enclosing herewith a plan that has recently come to our attention for development of prepayment medical service in Governmental bureaus. The potentialities of such a plan, if and when it is put in force in the capital city, should be readily understood.

"With hopes that I will have the pleasant opportunity of seeing you during the coming week, I am,

"Sincerely yours,
C. B. Conklin, M.D., Secretary."

He has gotten his plan. It was read to the jury—this "entering wedge to socialized medicine," as they called it. He has gotten authority to come down and see what he can do. He is a man that has been able to do wonders in these other cases. That is his job, and we know he came. What transpired at that meeting? It was not at the District Medical Society; it was at some club, I think. The committee that had charge of this particular job met at the Metropolitan Club, I think. I am not sure of that. But here is an A. M. A. representative stationed in Washington whom we find reporting religiously through the summer to Dr. Woodward in an effort to give him ammunition that he can use in writing this attack in the October 2 issue of THE JOURNAL—John F. Hayes. He writes and says:

"I attended the special meeting of the District Medical Society on the night of July 29. This special meeting was called for the purpose of hearing the report of the special subcommittee appointed to secure facts and information regarding the Group Health Association, Inc. . . .

"Dr. Sprigg read a formal and somewhat lifeless report reviewing the facts and information which had been obtained regarding the Group Health Association, Inc. Nearly all of his facts were substantially the facts which you and Dr. Leland had supplied to the group which attended the meeting here about two weeks ago."

I am not going to bore the court by reading the minutes of the July 29 meeting and showing you that long report which Sprigg's subcommittee had prepared and which Sprigg offered then; but there is testimony that nothing was in that report that Woodward and Leland had not supplied them with. So you may very well say that Leland was the author of it.

Does it simply rest on hearsay evidence that Dr. Leland was here? Oh, no. The meeting is heralded by Dr. Conklin. He tells his anxious confreres that help is coming from the mother—Woodward and Leland are arriving on July 12 to assist them. And then on July 27 he says what they propose. Woodward had a suggestion that quo warranto proceedings might be brought. They snatched at anything to gain their end. They were not satisfied to leave the enforcement of the law in the hands of law-enforcement agencies, but they were going to institute and did initiate this whole abortive attempt which they call of questionable legality—questioned by themselves for their own ends, stimulated by them.

But what does Leland suggest? Leland suggests another means. And I call your Honor's attention again to the indictment. Your Honor knows those cases which the Court of Appeals cited showing that the means need not be alleged at all. The indictment alleges certain specific means and also other means; and another means which is perfectly clear from this evidence was a belated attempt to urge competition with Group Health Association.

I wish I could take the time to trace that for you. But, oh, it is lurid!

First, there are contentions on the part of the defendant that it has been their fault, that the low-income group has not been properly take care of; that they have been backward. You remember the exhortation for them to wake up or otherwise they would get this socialized medicine that they feared so much, if they insisted on practicing repressive tactics.

And so, after Group Health Association had shown them the way—this horrible, unethical thing, as they would have you believe—they themselves decided to run in competition with it and combat it in that way. They use those very words. A number of them said the best way to combat it would be to set up another rival organization and enter into competition against it.

In April of 1938 they had a committee headed by Dr. Riddick to formulate a group prepayment plan just like Group Health, except it was the Medical Society's. Awfully unethical for anybody else to do it, but all right for us. Well, Dr. Leland is the man that gave them that assistance.

THE COURT:—That is what you advocate—competition, isn't it?

Mr. Lewin:—Free competition, but not the kind of competition this was.

Mr. Leahy:—Where is the evidence that Dr. Leland did that?

Mr. Lewin:—Here it is. Give me the minutes of July 27. He had a very amusing little plan.

THE COURT:—I am more interested in hearing you on the evidence against the individual defendants.

Mr. Lewin:—Yes, I am working now on Dr. Leland.

THE COURT:—So far as the law is concerned the law is laid down for me by the Court of Appeals, and there is no purpose in reading that.

Mr. Lewin:—I am not going to read law; I am going into the evidence concerning Dr. Leland. Here is what the minutes of the July 27 special meeting as reported by Dr. Conklin show to have occurred:

"The Secretary"—that was Dr. Conklin—"explained just what had been suggested by Doctors Woodward and Leland at the time of their visit." That was the July 14 visit, when they came to see what could be done with G. H. A.

"Dr. Woodward would advise quo warranto proceedings." "Dr. Leland had given a sketchy verbal outline of a plan whereby a pool of money could be created, and from this pool the care of the sick could be financed."

Well, the boys snatched at that; that sounded good, and so Conklin wrote out to get more details about it. First of all, I ought to tell you that Dr. West thought that was a good idea. He discussed a cooperative plan at the Metropolitan Club, and then went back and reneged on it. Maybe it wasn't wise for them to start anything in the nation's Capital; it might do some good.

Mr. Richardson:—Is that what he said? Are you making this up?

Mr. Lewin:—I am characterizing it. I am telling you what Leland did.

August 18, this man Leland writes back to Conklin:

"Dear Mr. Conklin:

"Since your letter arrived just as I was leaving the office for my vacation, I have had no opportunity to answer it until today.

"The suggestion which I made at the committee meeting"

Now, here is Leland's statement of what he said when he was here:

"is, in my opinion, a very simple one, involving nothing but cash payments to those who wish to participate. It is based largely on the type of arrangement that has been in effect for many years and operated by health and accident insurance companies."

Of course it was horrible for the G. H. A. to do that; a terrible thing for them to do, but it was all right for the A. M. A. and was suggested by this very man Dr. Leland.

"Briefly the plan would be for any group who desired to spread the cost of medical care to organize a benefit association or a mutual insurance company. The dues or premiums per member would depend on the amount of benefits to be provided. Benefits would be paid in cash to the beneficiary. They should be limited to $250 or $400 or $500 in any one year, but the benefit for any one illness should not exceed 75 to 80 per cent of the total amount of the medical and hospital bills for that illness.

"There would be no medical panel; every member would have the right to choose any physician in the District of Columbia or anywhere else in the United States; there would be no designation of approved hospitals; the patient would be perfectly free to choose his own hospital or go to the hospital to which his physician ordinarily takes his patients. Patients in hospitals would submit their bills to the organization according to the regular schedule of charges.

"The sole function of the organization would be to collect the dues or premiums from the members and to pay in cash to the members the amount of claims for medical or hospital services incurred for any single illness. Physicians and hospitals would then take their chances on collecting from the patients the amounts paid them for claims. There should be some sort of an identification card to indicate that the patient is a member of the organization. This would serve only to apprise the physician or the hospital that the patient would be reimbursed up to 75 or 80 per cent for the services rendered."

Here is the profession that is above all question of finance. "Physicians would then take their chances on collecting from the patient the amount paid them for claims. There should be some sort of an identification card" and,

"If the District Medical Society chose, it might authorize a 10 or 15 per cent reduction from the regular fees for members of such an organization, providing such an organization would be willing to make a settlement with the patient and physician or hospital jointly."

That doesn't sound anything like "finances" and "trade," does it?

"This is being done in some places and apparently works entirely satisfactory. In Iowa, for example, the reimbursement to members for the cost of hospitalization is made by check payable jointly to the member and the hospital. This affords an opportunity for the hospital to collect, since the member cannot cash the check without the signature of the hospital.

"If there are any further details in connection with this which you desire, I shall be glad to do my best to clarify such points as may not be entirely clear."

And that was signed by Leland, and he sent a copy to this same gentleman, Dr. Woodward, who came down with him.

All right now, on July 16 this same Woodward, this same Leland joined with Woodward in presenting a report to Dr.

West. On what subject? "Group Health, Inc., an apparent affiliate of the Home Owners Loan Corporation."

There it is in the evidence. Isn't there any evidence in the record that he knew anything about the situation?

THE COURT:—You don't need to read that.

Mr. Lewin:—I am not going to read it; I will see if there is anything else.

Mr. Kelleher (to Mr. Lewin):—Read the conclusion.

Mr. Lewin:—I will read you the last sentence:

"It (Group Health) is obnoxious to public policy for obvious reasons."

Who determines public opinion? Will you define it, and tell us what you mean by public opinion?

"We," says the American Medical Association, "simply reserve that indefinite, standard for our own use, so we can turn it on any outfit we wish, without giving any explanation for it."

Your Honor well knows that if there had been a tribunal set up by law delegated with any such rule-making power as to brand organizations as contrary to public policy the whole statute would be unconstitutional, because lacking in limitation upon the delegation of power. I am not going to cover that.

Here is the conference Mr. Leahy talked about. I don't believe he talked for it, but Leland was right there. Here it is, Nov. 6, 1937, affirmative proof that he and Dr. Woodward and Dr. West sat there with Drs. Hooe and McGovern. Why were they sitting there? Hooe started off by reading something that indicated why they were there. He read the standing resolution which seems so innocent to my friend. This was it. The Medical Society of the District of Columbia, at its regular meeting held Nov. 3, 1937 adopted the following resolution:

"That the President of the Medical Society of the District of Columbia appoint a committee of two members to go to Chicago as promptly as practicable to lay before the proper officials of the American Medical Association the views of this Society with regard to the activities of Group Health Association, including:

"1. That inasmuch as the movement threatens to be nationwide in its scope, and affects every component organization of the American Medical Association, it is the duty of the American Medical Association to oppose immediately with all its might this entering and possibly illegal wedge to the socialization of medicine.

"2. That in view of the tremendous import of the Group Health Association movement to the membership of the Medical Society of the District of Columbia, and also the profession at large and to the public, it is the opinion of the Medical Society of the District of Columbia that it is the duty of the American Medical Association to combat vigorously Group Health Association, Incorporated.

"3. That the Medical Society of the District of Columbia waives any question of regional interference by the American Medical Association.

"4. That the American Medical Association give a definite and immediate expression of its intended action in this matter."

Mr. Lewin:—That was the resolution passed by the Society which was submitted by Dr. Stanton.

Now, there follows the transcript of the plottings that occurred at that meeting; and again it is my pleasure to correct my brother when he says that all that came out of that was some advice to get legal counsel. The doctors who left the District of Columbia to go out there for advice and assistance laid their cards on the table. They even went so far as to tell Leland and the others about these hospital boycotts. That was at the Sunday night meeting, it must have been October 31. They all met together and decided to put pressure on the hospital staffs. They wanted to know whether that was risky. One spoke up and said, "That is reasonable. Will the hospitals do it?" Woodward said it might invite some Congressional action if they did that. The propriety of doing the thing was not questioned by them; the question was whether the hospitals would do it. I just point that out as showing there was a thoroughgoing discussion of the whole issue; of the plottings right there in the presence of Dr. Leland.

Mr. Leahy:—Now, you know that is a misreading of the evidence.

Mr. Lewin:—No it is not. You can't talk to me that way, because I have it right here.

Mr. Leahy:—I can talk to you that way and tell you that it is not that way.

Mr. Lewin:—I will not be challenged and not make good on it. Give me the part about the Lee and Scandiffio expulsion proceedings gone into at that meeting.

THE COURT:—Pass on to something else.

Mr. Lewin:—Is your Honor satisfied with my statement? Here it is:

"The operation of Group Health Association began on Monday last. Two members who contracted with Group Health were members of the District Medical Society. The third had sent in his application which had been withdrawn within the past ten days. There was nothing to be done about this third member at the present time."

That was Dr. Hulburt.

"The resignations of the other two were received by the Medical Society of the District of Columbia within the week. A letter was sent to each of them asking him to appear before the Compensation, Contract and Industrial Medicine Committee. They did not appear but the Committee received a communication from one of them. The Committee unanimously recommended to the Executive Committee of the Medical Society of the District of Columbia that disciplinary measures be taken.

"Dr. Woodward raised the question as to whether the notice to these members had told them of the charges that were to be preferred against them and stressed the necessity for following strictly the procedure as laid down in the constitution and by-laws of the Medical Society of the District of Columbia. Further discussion was deferred to a time when it could be gone into in detail by Dr. Woodward.

"Dr. Hooe: In the matter of the H. O. L. C., what is your future program?

"Dr. West: It is just exactly the same as it has been all the time. We shall continue fighting it in every way we can. We are going to get all the help we can get. We are at least going to keep on until we are instructed otherwise."

Mr. Lewin:—Then here is what Dr. Hooe says:

"Dr. Hooe: Executive Committee recommended that a letter be addressed to the Medical Boards of the various affiliated hospitals in Washington, calling attention to the H. O. L. C. health group, insisting that the hospitals take cognizance of it, and, among other things, calling attention to the fact that the physicians employed by such group are not acceptable to the Medical Society of the District of Columbia.

"In reply to Dr. McGovern's question as to how far the Medical Society of the District of Columbia might go in controlling the hospitals, Dr. West expressed some doubt that the Society can effect such control."

There weren't any plottings at all there.

Taking up Dr. West's expressed doubts as to whether the Society could control the hospitals, Dr. Hooe asked:

"Is it not, in your opinion, most reasonable that the hospitals should acquiesce in this matter?

"Dr. West: It is reasonable that they should do it but as to whether or not they will, that's another question. Suppose they don't?"

and then there is more of the same sort of thing. A complete exposé of what was going on there in the presence of Leland.

Now, there were a few other documents in regard to Leland. One, Woodward writes to Conklin August 18, copy to Leland. He says:

"Dear Dr. Conklin:

"I thank you for your letter of August 14, stating the present position of the Medical Society of the District of Columbia with reference to the Group Health Association.

"I understand from your letter that everything that was said and done by Dr. Leland and me in the course of our recent conference with the Committee then having the Group Health Association under consideration is now before the Committee duly appointed to study the matter. If there is anything in what either of us said or did that was obscure and that calls for explanation or elaboration, we shall be glad to undertake to explain or elaborate it for the information and guidance of the Committee. Neither of us has at the present time any further proposal looking toward forestalling the growth of the Group Health Association or toward preventing the organization and growth or similar groups in the District of Columbia."

Now, what is the upshot of all this? I can't go along all day on one defendant. What is the upshot of it? It means perhaps that Leland did not suggest the blood-curdling things as did some of the others. It might be that a jury in its exercise of discretion might feel they would wish to relieve him, but certainly can anybody seriously argue, in the light of all that contemporaneous, documentary evidence that Leland did not know about this plan; that he did not confer with the rest of the conspirators, and that he did not hear and make suggestions with regard to it? It is just impossible for any serious, bona fide argument to be made, and so I say to your Honor, your task with regard to Leland is simple.

Now, a word in regard to Fishbein; and I wish I could take more time on this. The testimony with regard to Fishbein rests so largely on that A. M. A. article. You will recall when the Board of Trustees, when they authorized Woodward and Leland to come here to Washington to advise, authorized West and Fishbein to make this announcement to the public, or the profession generally; that was it, the profession generally with regard to H. O. L. C. Now, what happened? The way they had to bring this out to the profession generally was through THE JOURNAL, and who, if you please, was the editor of THE JOURNAL, and responsible for every line that went into THE JOURNAL. The defendant Fishbein.

Now the evidence shows that it is perfectly clear he passed himself upon that specific issue. The same Dr. Woodward was assigned the task of writing up the draft of the article, and he wrote up that draft and then the evidence shows he sent that

draft to the defendants West and Fishbein with a written communication in which he called their attention to the fact that they had been authorized to do such a thing, and here it was.

Now then, my friend Mr. Leahy, who accuses me of misstating the evidence, tells you there isn't a line as to Dr. Fishbein. There is a letter back from Dr. Fishbein. This is what Dr. Woodward sent to the Board of Trustees of the A. M. A.:

"At the meeting of the Executive Committee of the Board of Trustees of the American Medical Association, June 29, 1937, a resolution was adopted authorizing the editor and the secretary and general manager to inform the medical profession of the country as to the ethics of the Home Owners Loan Corporation to enter upon the practice of medicine and as to the present status of the proposal to organize cooperatives by the Government. In response to your request for information concerning the matter, I submit the following report."

And it is signed by Dr. Woodward. The memorandum is for "Dr. West and Dr. Fishbein." It says:

"To avoid possible conflict on my part with the attached canons of professional ethics of the American Bar Association, I am submitting the accompanying material to you in the form of a report."

That is Dr. Woodward; he is lawyer and doctor.

"If you decide to publish it, I hope that my letter will be published along with it so as to make my status clear. If you think the letter should be addressed to you or either of you, change can be made accordingly.

"The minutes of the meeting of the Executive Committee, June 29, 1937, show the adoption of the following resolution:"

Now I will give you the reply:

"I am returning herewith the duplicate of the report on the H. O. L. C.; the original is being edited for use in the Organization Section of THE JOURNAL.

"Morris Fishbein."

That is in evidence.

Woodward had already written that Fishbein didn't believe he could run the article at a certain time but expected to run it at another time. How did the article come out, and what did it do? Mr. Leahy says after the article everything started. Everything started after the Woodward article, so he says, and although it is not strictly accurate, the fact is that after the article appeared the defendants really did get down to business. Why? Because these minutes will show that up to that time while there had been a great deal of plotting, in the words of Conklin some people suggesting boycott, there had also not been complete unanimity of view in the District Medical Society. Some of the more liberal members seemed to think that it was incumbent on the District Medical Society to go along if they could save their faces by doing so with Group Health, or develop some kind of a prepayment plan, recognizing the crying need for it. So, in the late summer, the McAtee committee brought in what Dr. McGovern characterized as a rather weak report, in which he wanted the Society to go on record as being in favor of some kind of a prepayment plan, and when he brought that in he called attention to the fact that in a little while there would be an article in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION which they should read for their "guidance and advice," I think the phrase is. Notwithstanding that article, he thought this more liberal report might be passed. Then the article came down and that swung the Society against any liberal view; against any expression in favor of a prepayment plan, and over to the strictest kind of opposition and boycott of Group Health, and everything it stood for. And Dr. Groover, who is now dead, was the gentleman who offered that substitute resolution, which your Honor may recall. He is commended for it by the rest of the defendants, a number of them. He said, "This is the kind of fighting resolution that we ought to have brought in in the first place." And I think Dr. Sprigg excused the Committee that brought in such a weak report, although he praised Dr. Groover's substitute, by saying "We didn't have the benefit of this article from the American Medical Association when we were deliberating." I am going to quote from memory here, and I won't be accurate, but there were recitals in the Groover substitute which turned its back on any liberalizing. There were recitals there with regard to this A. M. A. article; that the District Medical Society was on record in favor of what was said there, expressed in that article, and the implications to be drawn therefrom.

Now, you might not have drawn those implications, if you had read those articles in a publication, and I might not, but when you consider the circumstances under which they were written and published by the American Medical Association, and when you consider the interpretation intended to be placed on it by the District Medical Society, you will see how very important that article became and was; because that article, after a long rambling description of Group Health, most of it based on very inaccurate information and a lot of theorizing about the law, which turned out to be utterly groundless, turns to the implication. These are the sentences which certainly must be the ones that carry the implication. This article, written for a purpose and used for a purpose, not as a statement of fact; not the same kind of freedom of speech they wanted to deny poor Dr. Richard Cabot, who happened to make an address here at the Group Health banquet and then was called on the carpet by the American Medical Association and referred to his local society for disciplinary action; not that kind of freedom of speech that they wanted to report there—no, but dynamic freedom of speech: That was the instrumentality for the accomplishment of the design, and that instrumentality was adopted and published by the defendant Fishbein in the Organization Section of the publication. But before I get to that, let me tell you another interesting thing. Some way they thought that, if they could discover that the Filene Foundation had contributed moneys to Group Health, they would have a very weak point. Why, I have never been able to understand. As a matter of fact, the Filene Foundation had not been contributing anything to it, except advice; but, nevertheless, suppose it had contributed a very substantial sum of money. I have always failed to follow or understand their reasoning in this connection. Assume the Foundation took the position that these people were sincere but that perhaps because they didn't have sufficient financial standing they weren't "economically sound" but that it wasn't just a bubble, and that they did advance some financial assistance. Well anyway, these people didn't know; they thought it might be a weapon if they found out, so they adopted this surreptitious way to make the discovery. Instead of writing to the Foundation, Dr. Fishbein suggested that Dr. Woodward get some third party, not identified with the A. M. A., to write a letter to the Filene Foundation and make this inquiry. Now, mind you, they are getting ammunition for this article, which I am going into in a moment; and here is this clever idea of smoking out what they said would be this dangerous fact, and they go so far as to suggest the type of letter that this third party should write; this third party who is not to disclose his interest or identity, is to write.

Mr. Leahy:—Is that in evidence?

Mr. Lewin:—It is in evidence. Exhibit 185.

THE COURT:—Let us go on. This case must proceed tomorrow.

Mr. Lewin:—I have not been talking an hour and a half.

THE COURT:—I heard Mr. Leahy for an hour and forty minutes; I am going to hear you for a couple of hours.

Mr. Lewin:—In answer to the suggestion that Dr. Fishbein didn't suggest this surreptitious letter—here it is in Exhibit 185—we say here is the article, and the implications to be drawn from the article:

"As the members of the salaried staff of the Association are likely to be looked on by the profession generally in the community as on the outer verge of ethical practice, if not altogether beyond the pale, it is not clear how they are to obtain qualified consultants or procure hospital service for their patients."

This salaried staff is to be looked on as beyond the pale, although the salaried staff of the A. M. A. can plot against them. There is the implication; withdraw consultation, and keep them out of the hospitals, and it is repeated.

"In any event, medical service under the Association would be likely to be handicapped by difficulties likely to be experienced in obtaining the best consultant service and hospital accommodations. Physicians who sell their services to an organization like Group Health Association for resale to patients are certain to lose professional status."

Now there is the act; you have the boycott. That is the boycott that is charged; the boycott which the proof shows was carried out.

Now, this dynamic prompting was authorized by the Board of Trustees and carried out by the defendant Woodward, West and Fishbein and taken to heart for the information and guidance of the local defendants to such an extent that they ordered 1,000 extra copies and distributed them among the entire membership for their information and guidance, and from that prompting came the attack on the so-called illegality of Group Health, and from that prompting came the consultant boycott and the exclusion from the hospitals.

Now, in view of your Honor's remark that you don't care to hear any more, or very little more——

THE COURT:—I didn't say that; I suggested I would be glad to allow you two hours. I would like to hear the evidence as to the other defendants, these individual defendants.

Mr. Lewin:—I could have made my argument much shorter if I had discarded the evidence. I thought your Honor did not wish me to do that.

Mr. Kelleher:—I propose to deal with the individuals in the local Society and the defendant, Washington Academy of Surgery, if your Honor desires to hear some discussion on the latter.

THE COURT:—I should like to hear as to the local membership.

Mr. Kelleher:—How about the Washington Academy?

THE COURT:—Yes.

Mr. Kelleher:—I will commence with it, then. The evidence shows that on January 29 and January 31, 1938, defendant Washington Academy of Surgery recommended to four hospitals, Columbia, Providence, Georgetown and Garfield, that they disapprove the application of Dr. Selders for courtesy privileges. The question presented, if your Honor please, is whether this act, obviously in furtherance of the conspiracy, was done by the defendant with the knowledge and for the purpose of doing something in aid of the conspiracy. Very briefly I shall cite four reasons, disclosed by the evidence, why your Honor must conclude that there is a prima facie case at least which requires explanation by them, or by that defendant, concerning this action.

First, the meeting of that Academy on Dec. 10, 1937, the minutes of it contain the following:

"Discussion concerning G. H. A. It was suggested that the professional qualifications of the surgeons of that organization alone be considered, as a matter of public policy. However, a motion was passed requesting the hospital privilege committee to consider the ethics of any applicant as well as his strictly surgical training; ethics were understood to be as defined by the American Medical Association."

Your Honor will note that this resolution of the Academy on December 10 was adopted at the suggestion of Group Health; second, that the resolution, the purpose of it, was to test the right of Dr. Selders to participate in any of the hospitals on the basis, not only of his professional qualifications but on the basis of his ethical qualifications; and I don't think I need go any further, so far as this evidence is concerned as to what was meant by the word "ethics," the tyranny of that word has already been referred to by Mr. Lewin. What was meant was the participation with G. H. A.

THE COURT:—What was the report of the Committee?

Mr. Kelleher:— We don't have in evidence the report of the Committee, but we have letters from Dr. Fishback to the four hospitals stating the Committee had recommended against the granting of courtesy privileges.

THE COURT:—Do the minutes show the nature of the report?

Mr. Kelleher:—They do not; they show the action of December 10th.

THE COURT:—Is there anything in the letters or reports of the hospital to indicate whether it was passed on in one way or another, or both?

Mr. Kelleher:—They give no grounds whatsoever; so we must look behind to see what the grounds were. That is the first point.

We also have in evidence a letter dated December 9, from Dr. Fishback, the Secretary of the Academy, to the Chairman of the Hospital Credentials Committee, and this is what Dr. Fishback says:

"I am anxious to talk to you." That is Exhibit 446-A.

"I am anxious to talk to you before you reach any decision on Dr. Selders, especially if there is feeling that he will be disapproved purely because of his connection here in Washington. As a matter of policy and tact, and I believe for the good of general public attitude toward the profession, the question of his relationship to the Group Health Association, Inc., should not be permitted to enter the discussion."

Bear in mind, this is December 9th, the day before the Academy rejected this suggestion of Dr. Fishback and decided to consider the matter, and let me show your Honor the circumstances indicating the mutuality of interest between the members of the Washington Academy and the members of the local Society.

In the first place, the evidence shows that every one of the forty-eight members of the Washington Academy of Surgeons was also a member of the District Medical Society. By stipulation the names of the officers and of the members of the Hospital Credentials Committee appear in evidence. Two of the members of the Academy were the defendant Christie and McGovern; two of the most active in the conspiracy. The president of the Society, Dr. John A. Cahill, was on the Executive staff of Georgetown Hospital, attended the meetings of that Committee at which G. H. A. and Dr. Selders were discussed, and at which action against Dr. Selders was taken. He was present at the October 2nd meeting of the Society at which the resolution concerning the adoption of THE JOURNAL article and its implications was adopted. Furthermore, the members of the Advisory Committee, the Committee which was instructed to consider the ethics of the applicant, were also members who were active in the conspiracy for the Medical Society of the District of Columbia. Dr. Lyons, Chairman of the Committee, was a member of the Medical Staff of Childrens, and was present at a meeting of April 4th of that staff, at Childrens Hospital, at which a resolution was moved for adoption that Dr. Wall be instructed to arrange for a meeting of the members of the staff of the various hospitals to "adopt uniform rules concerning admission of G. H. A. patients in hospitals."

He attended the July 29, 1937 meeting of the Society, at which G. H. A. was discussed, and the Committee appointed to discuss the matter. The second member of that Credentials Committee, Dr. Barton, was a member of the Executive Committee of the District of Columbia from April 1937 to July 1938. He attended meeting after meeting of that Committee, at which all of these matters were discussed; and I have these meetings here and am prepared to discuss them, if necessary.

In addition, he was present—and let me point this out—at the October 11th meeting, November 11th meeting, at which the special hospital committee made its first report and suggested that Group Health patients be treated only by members of the staff of the hospital; and that report, your Honor will recall, was referred back because there was a little hole in it, namely, because Group Health doctors might already be members of the staffs.

The third member of this hospital credentials committee of the Academy was Dr. Fred Sanderson, and who the evidence shows was a member of the C. C. & I. N. Committee of the Society; the very Committee which preferred charges against Lee, and the evidence further shows that Sanderson, in the absence of Hooe, brought out the charges of the C. C. & I. N. against Dr. Selders.

The fourth and last member was Dr. A. L. Riddick, and he was a member of the staff of George Washington, which failed completely to take any action whatsoever upon Dr. Selders' application. He was present at the meeting of October 15 and at the meeting of November 11 of the Society, already referred to; and he was present at the meeting of March 2, at which the Executive Committee recommended that Dr. Scandiffio be expelled. These circumstances clearly show what the Academy was doing in considering the ethics of the applicant; and, secondly, that the very parties who were active in the Society and in the hospitals in the city against Group Health were sitting on these committees which passed upon the ethics of applicants. Now, finally, and this is the last point on the Washington Academy, if there could be any doubt left in your Honor's mind, this evidence will dispel it.

The motion, the motion that the Credentials Committee consider the ethics of applicants was made by none other than Dr. Warren Segar. Dr. Segar was a member of the Hospital Committee of the District Medical Society, the very Committee which was charged by that body on November 3 to carry out the hospital phase of this conspiracy. It is stipulated that Dr. Segar during the period from July 1, 1937 to July 1938 was a member of that Committee. He was present at the meeting of November 3, when the hospital resolution was adopted, and also he responded to the letter of Dr. Warfield of February 3, with which your Honor is familiar; the letter in which Warfield requested information from all members of the Committee concerning the activities of the hospitals of which members were members of the Committee, concerning the G. H. A.

Now that, your Honor, we submit clearly raises a prima facie case against the Washington Academy of Surgeons.

First, the minutes; second, the Fishback letter; third, the fact that the committee considering Selders, the officers of the Academy, were active in the Society pertaining to the case; and finally the fact that Segar, one member of the hospital committee, was the one who put this resolution motion in the Washington Academy of Surgeons.

Now, your Honor, let me come now to the same defendants to which Mr. Leahy referred this morning.

As I understand it, he urged the Court to direct a verdict for the defendants Young, Martel, Yater, Christie and Stanton.

THE COURT:—I didn't hear him mention Yater.

Mr. Kelleher:—He made this observation, your Honor. He made just a single resolution. I might as well dispose of this

thing right now. If Dr. Yater isn't in this thing, nobody is. The hospital committee was designated on November 3 to then determine and report back to the Society on means for bringing to the attention of the hospitals the attitude of the Society concerning G. H. A. And you remember that resolution and the recital that the Society has in its power to hinder and obstruct G. H. A. if it can prevent patients of that organization from gaining admission to the hospitals.

Incidentally, Mr. Leahy says the mere fact that Dr. Christie seconded that resolution doesn't mean anything, that that is not in evidence against Dr. Christie.

As a matter of fact, he did second it, and Dr. Prentiss Willson introduced it.

Now, what did Yater do?

On November—

THE COURT:—Is he on the committee?

Mr. Kelleher:—No, he is not, but I will explain his connection.

On November 11, just eight days after this committee was designated to act, Dr. Warfield reported back for the committee and this is what he said.

He said: "The committee had a meeting in my office a few days ago concerning this matter, concerning the November 3 resolution.

"It is the view of the committee that the Society should recommend to all of the hospitals that patients of G. H. A. may be treated in the local hospitals but that such patients may be treated only by the members of the staffs of the hospitals."

But the hospital committee had been careless, and Yater pointed it out.

He pointed this out, your Honor. He said:

"Oh, well and good, but there is nothing to show, so far as we know, that G. H. A. doctors are not on the staffs of these hospitals or that they might not become members of the staffs."

And so, on a motion made by him—this is his motion of which Mr. Leahy spoke this morning—on a motion made by him this first resolution of the hospital committee was recommitted to the committee with instructions to come back with something else because this had this dangerous loophole in it.

And as a result of that motion of the defendant Yater the hospital committee came back on December 1 with the December 1 resolution recommending that all hospitals have on their staffs only members of the local society and of the A. M. A.

Now, that is Yater's participation.

Of course, Yater was on the staffs of the local hospitals.

Now, let me come to the defendants Martel and Young, because I think we completely disposed of Yater and Christie.

Certainly if there was an action at any time in this conspiracy of any kind whatever it was the action of Willson, Christie, and Yater.

To consider Young and Martel it is necessary for me to stress, if your Honor please, what I don't believe your Honor is aware of, and that is the significance of the action of this hospital committee of the D. M. S.

As I have said, it was this committee which was charged with arranging to carry out one of the most important phases of this conspiracy, the hospital boycott.

It was charged on November 3, it reported back eight days later with this resolution which Yater had recommitted.

It reported again on December 1, reported through its chairman, Dr. Warfield, a defendant in this case.

And then the defendant Mattingly—on motion of the defendant Mattingly on Feb. 2, 1938 that the proper agency of the Society investigate what the hospitals were doing with respect to G. H. A. preliminarily to disciplinary action by the Society in the event that any of the hospitals were not complying with its wishes—and let me show you what the evidence shows—concerning the means which the hospital committee took—and this bears directly on Martel and Young—the means which the hospital committee took to determine whether or not the hospitals were complying with the wishes of D. M. S. preliminary to action by the Society in the event they were not.

The action shows—the evidence shows that immediately thereafter, the day after this resolution was adopted, Dr. Warfield communicated with every member of the committee to ascertain what each hospital in the District of Columbia was doing.

And I think I should observe here that each of these members of the hospital committee represented a particular hospital.

There were only eleven members and eleven hospitals in the District, and each of them represented a hospital.

So Warfield communicated with each one of the members of that committee, and that is the evidence in this case, your Honor, by this letter of February 3 requesting information concerning what the hospitals were doing.

Now, let me show you—Before I do that—Before I come to the evidence about Young and Martel let me make these observations:

After he had done that he sent a questionnaire to all of the hospitals and this questionnaire was returned by various members of the hospital committee with the various blanks filled out.

I don't think your Honor would have any difficulty in looking at that questionnaire and concluding that it was part of the duty of that hospital committee delegated to it by the Society on February 2 as a result of Mattingly's resolution.

Then what did he do?

He took those questionnaires, made that pencil notation which your Honor saw, listed the various hospitals, listed the various inquiries and then he put on 0-0-0 all the way through so far as the membership for G. H. A. doctors was concerned, and "Yes" as far as cooperation with the D. M. S. was concerned.

And in that your Honor will note—Sibley has one member on, Scandiffio.

The questionnaire shows that that hospital with Scandiffio's name is stricken out.

Now let me show you how this ties up with the official action of the Society.

On March 28, 1938 the defendant Warfield reported to the Executive Committee that—and I quote—

"All of the local hospitals are cooperating."

And that meets the Scandiffio claim of his rough draft.

All of them are cooperating.

Only one, and that is Sibley—has a member of G. H. A. on its staff, and that hospital has given assurance that it will take steps to exclude that doctor. Now, where is the importance in this, your Honor?

It is important for this reason, so far as Young and Martel are concerned.

This is the action of that committee, and the resolution, the mechanics taken by a committee acting continuously from Nov. 3, 1937 until April 1938.

And here is what Young did:

Young answered the letter of February 3 in the following way—Young represented Casualty Hospital—and he said this:

"To date we have had no application from any physician or surgeon connected with Group Health Association.

"If there is any further information I can give you regarding this matter, I shall be glad to cooperate with you in any way."

THE COURT:—Was he a member of this hospital committee?

Mr. Kelleher:—I am going to come to that right now, your Honor.

I call attention also to the fact that he filled in this questionnaire which Warfield sent to every member of the committee.

That questionnaire for Casualty is identified as having been filled in by the defendant Young.

Now, let me come to your Honor's question.

The stipulation does not show that Young is a member of the hospital committee of the Society.

It shows this, however, it names all of the members, and then states "Proof of additional members may be made by either party in this case."

What does the proof show?

The proof shows first, Exhibit 312, which has been identified by Dr. Warfield's secretary as having been prepared by her under the direction of Warfield, that exhibit carries a heading "Hospital Committee" and included in that list of members of the hospital committee is the defendant Young for Casualty.

Second, your Honor heard the testimony of Rogers on the last day of the trial; president of the board of directors of Casualty Hospital.

And let me quote that evidence so that there will be no mistake in the matter:

"My recollection is"—

and this is in response to questions by Mr. Lewin—

"My recollection is that I knew that he"—

and he is speaking of Dr. Young—

"was a member of the hospital committee. I was probably informed by him, I don't know just when, I don't know whether he succeeded Dr. Lewis."

But I combined this statement with Exhibit 312 which shows his membership on the committee, and I don't think there can be any question; but whether there is a question, the fact as to whether he served on that committee; and combined with the additional fact that the evidence shows that Lewis was out of the country and in Panama and never returned, and that he was a representative of Casualty until he left; combining the additional fact that Young filled out the questionnaire for Casualty; that he answered the Warfield letter of February 3; and I submit that there could be no doubt in any reasonable man's mind on that phase, on this letter, that Young was a member of that committee and was acting—and was engaged in the activities of that committee, the important activities of that committee which led to the exclusion of Dr. Selders and the other doctors of G. H. A. from the staffs of the local hospitals.

Now, one other fact concerning Young. I assume your Honor wants these details?

THE COURT:—Yes. I will give you a little time. Without going into too much detail. I remember the evidence pretty well. Just call my attention to the details.

Mr. Kelleher:—My point is this:

Mr. Leahy says we should segregate each act and put it under the microscope of the law, as he so picturesquely puts it; but you cannot do it that way. When we find any act here, it must tie that individual up with that committee if he is a member of the committee.

Now, in addition to the activities of Young on the hospital committee there is this further fact:

Young was on the credentials committee of Casualty.

Bear in mind, your Honor, that the hospital committee was instructed to develop some means for bringing to the attention of the medical staffs and the boards of directors of the local hospitals the attitude of the Society towards G. H. A.

Now, here is Young on the staff of that hospital. And what was the action of the hospital?

First, the action of the credentials committee.

And that is Exhibit 590. And this is what Young recommends:

"The application of Dr. Raymond E. Selders has been duly considered and it is the opinion of this committee that the qualifications and experience of this applicant at this time are such that disapproval of the application is recommended."

No other explanation. Nothing further. Nothing to show whether his qualifications were ever considered, but all of these circumstances showing that the defendant Young was in this thing up to his neck.

Your Honor I think will also recall the fact that Mr. Kirkpatrick testified that he had a conference with Young and Rogers.

THE COURT:—Yes, I remember.

Mr. Kelleher:—In June 1938.

Now let me come to Martel. Martel is also on this hospital committee. It was so stipulated. He is also on the Georgetown staff. By virtue of the resolution of November 3 he is the one who was elected to bring to the attention of the medical staff and the board of directors of Georgetown Hospital the attitude of the D. M. S. towards G. H. A. Now, let us see whether he did it (examining paper). Exhibit 516 is minutes of the executive committee of the hospital staff, Jan. 20, 1938; shows that Rodriguez, Sister Rodriguez, requesting instructions concerning an emergency case in the hospital, and asking whether after forty-eight hours Selders should still be permitted to treat the case. The minutes say Martel thought Penniman was pressing Rodriguez on a good opportunity. Martel moved to inform Selders that an emergency no longer existed. That is Exhibit 516. This is the gentleman of whom Mr. Leahy said there was no evidence whatever.

Mr. Leahy:—You don't call that evidence, do you?

Mr. Kelleher:—Don't say I don't. Say you don't.

He was also present at the meeting of March 10, 1938, another meeting of Georgetown. And here is what happened there. The Berry letter was read. Your Honor will remember that letter. Inviting these hospitals to a meeting at which G. H. A. should be discussed. And here is what happened: A resolution was adopted at this time that any G. H. A. patient would be admitted and cared for by the doctor of his choice if that doctor was on the staff. And here is what Martel says. Martel says, "Now, Scandiffio is qualified but he has done something the hospital does not approve and G. H. A. would like to have somebody say so." And Martel first declined to go, finally, April 3, 1938 Martel appears at the meeting of the executive committee again. And here is what happened there: Sister Rodriguez requested a ruling on a patient of Hulburt's, and that, your Honor, was the Moriarity case, about which Hulburt testified. On motion by Stanton—and this is evidence on Stanton again—on motion by Stanton the hospital moved to adopt definition of Children's Hospital concerning emergency cases. Now, what do these minutes show so far as Martel is concerned? At the very last they show that the defendant Martel was participating with knowledge in the meetings of the hospital in which G. H. A. was considered. What was the action of the hospital? That document was introduced this morning. In that document Selders was notified that his application for minor surgical, major surgical and gynecological cases was rejected. No explanation whatever. Rejected, your Honor, for minor surgery; surgery which Halstead testified any general practitioner is qualified to perform.

No explanation for that!

What other reasonable explanation could there be than that Martel, the representative of the hospital committee in that hospital, was succeeding in persuading that hospital to reject Selders because of his connection with G. H. A.

One other defendant, then, and I am through, and that is the defendant Reede. The defendant E. Hiram Reede. Mr. Leahy says that all he did—and how anybody could do much more I am at a loss to explain—but all he did was to sit in the Lee and Scandiffio trial. But here is what he didn't bring out; I believe he didn't bring out that the defendant Reede was the officer who presided at that trial and ruled throughout the proceeding. Now let me point out one brief quotation. (Examining paper.) Well, your Honor, I am referring to the proceedings of the Scandiffio and Lee proceedings, and as I understand your Honor's ruling—

THE COURT:—That is in as to one purpose?

Mr. Kellcher:—It is in as to what the defendants knew and did.

THE COURT:—What is that?

Mr. Kelleher:—There is some understanding.

THE COURT:—It was in for the purpose of showing who was there.

Mr. Kellcher:—Only for the purpose of showing who was there. It shows the defendant Reede was in attendance there.

And let me show you what the minutes show, and I think I can correctly characterize the other evidence in the case.

On December 10 the minutes show that the C. C. & I. M. Committee reported to the executive committee that because Lee had agreed to resign from G. H. A.—to resign from G. H. A.—the C. C. & I. M. Committee was recommending that the charges against him be dismissed. And at this meeting, and this was the meeting at which Reede was presiding, and I believe the minutes show that he read that report of the C. C. & I. M. Committee—then on motion of somebody in the executive committee the charges against Lee and Scandiffio—or against Dr. Lee, were dropped. And as a result of these proceedings the charges against the defendants in that case in which the defendant Reede in this case presided, Dr. Scandiffio was expelled from the Society.

I thank you. I am sorry, your Honor. There is one other point and that is the Harris County. Would your Honor care to hear me?

THE COURT:—Proceed. Yes. I would like you to summarize what you understand.

Mr. Kelleher:—Yes, your Honor.

Let me briefly summarize first what occurred down there, as I understand it. The evidence shows that Homer Taylor was chairman of the State Association. Early in the fall—late in the fall, around October and November of 1937, Homer Taylor was communicating with the defendant Conklin. He was communicating about G. H. A. And here is what Conklin wrote Taylor on October 30. He stated that G. H. A. was progressing, that a banquet was being held, and of course the president of the Society chair at that banquet would be another empty chair.

Then he goes on:

"The staff is made up of three doctors, and you may have some interest in this in view of the fact that one of the doctors is a member of the Harris County Medical Society."

Taylor then replies to Conklin and says:

"Please let me know as soon as possible so that charges of unethical conduct may be successfully lodged against Selders."

Now, here we get to the Harris County Society.

On Nov. 25, 1937, Ashburn, the superintendent of Columbia Hospital, dictated a communication to the secretary of the Harris County Society stating this:

"We seek your"—and I am paraphrasing—"We seek your aid in determining the qualifications of Selders. Selders is an employee of an H. O. L. C. cooperative. The movement has caused"—and I am quoting—"much opposition in local medical circles. Selders"—and I quote again—"while educationally a well-trained man has not submitted evidence of special training."

And then he says this:

"Because of the special circumstances of the particular case, any assistance you can give will be appreciated."

And what does Coole reply? Coole, who was on the staff, and secretary of Harris County, he says:

"The record shows he is well qualified."

In addition he has also learned that he took a postgraduate course at Pennsylvania, and this should add to his training.

"His record is clear but I have been informed that he is employed with H. O. L. C. Our board of censors is investigating."

And then this:

"The Harris County Medical Society strictly condemns any such practice and if the allegations are found to be true, Selders will be subject to disciplinary action."

What occurs after that? Talley writes to Conklin, and Talley was the chairman of the board of censors of Harris County, and he writes this:

"Harris County is very anxious to know the medical status"—

not of Selders, but of G. H. A. That is what they are anxious for. Of G. H. A.

"We are also anxious to know the ethical standing of the men who compose this staff, as one of the staff members belongs to our local society."

Conklin replies immediately, Jan. 19, 1938, Exhibit 80, and this is what he says; he describes the expulsion proceedings which have been instituted against Lee and Scandiffio.

There is suggested now about what Harris County Medical Society ought to do. He points out that one of the doctors, Dr. Lee, resigned after the first night of the trial, and the other doctor however has continued and he no doubt will be expelled.

THE COURT:—Do you have the individual members, officers, of the Harris County Society as defendants?

Mr. Kelleher:—No, your Honor. Just the Society.

Talley reported—here is the action of the Harris County Society:

Talley reported—and this is January 26, the first of the year, Talley reported on the matter of one of our members affiliated with a contract organization in Washington, D. C.

This report was adopted.

Now, what was the action of the Society that day?

That is shown by a letter from Talley to Selders dated Jan. 31, 1938, and this is the crux of the matter, and I shall read an excerpt from the letter.

The board of censors reported to the Society that from their interpretation of the code of ethics of the American Medical Association that it was unethical for one of our members to accept a position of this kind.

This interpretation was upheld by unanimous vote of the Society. This interpretation that association with an organization of this kind is unethical was upheld by a unanimous vote of the Society. And that is the chairman of the board of censors writing to Selders. And will your Honor note this last significant sentence:

"Hoping you will continue to be with us and that we may hear from you immediately."

What more could there be for a suggestion that the best thing for Selders to do if he wanted to be with them was to resign from G. H. A.?

Selders wrote back requesting a frank statement of the grounds of the charge against him.

Then Talley—well, your Honor, the evidence shows that the Harris County Society tried to pass the buck, and that is about all it amounted to, tried to pass the buck to the A. M. A.

So it referred the matter to the Judicial Council and asked the A. M. A. for a construction of the constitution, that is, whether since Selders was up here in Washington and not in Texas, whether therefore there wasn't a dispute between the D. M. S. and the Harris County Society, and therefore shouldn't the Judicial Council take them out?

Well, the Judicial Council rejected it. And then it went back to Harris County. And what occurred?

THE COURT:—I think I remember that pretty well.

Mr. Kelleher:—All right, your Honor.

THE COURT:—They decided it involved a legal question and they couldn't go any further.

Mr. Kelleher:—No, your Honor, they did go one step further. I would at least like to point out what we consider to be the significance of it; the evidence shows I believe that West wrote to the Harris County Society and said in effect, Look, there is a provision of the constitution which provides that if a member of a local constituent society leaves the state and goes to some other state and doesn't take out membership in another state society, he loses his membership in that society. In the local society, from which he leaves.

So what do they do? They require Selders to transfer or to make application for transfer from Harris County to the D. M. S. And the last thing the evidence in this case shows is that his application for transfer is accepted. And what is the result, your Honor? What other result could there be than that they got him out of the Harris County Society and now they are going to leave it up to the defendant D. M. S. to keep him out? And the indictment was returned about a month later.

THE COURT:—Well, they refused to take any action against him being employed in G. H. A.

Mr. Kelleher:—No, your Honor. There are two answers to that. In the first place, they did take action. The board of censors found he was unethical. The Society adopted it by unanimous vote. Now, that is the first thing. This action against him. It is clearly conspiring. And the evidence shows it was done to induce him to leave G. H. A. They were trying to discredit this man and to get him out of the A. M. A. But after going through all these steps they found a simple way to do it, and that was to make him transfer. Get him out of this Society, and he cannot get into the D. M. S., and he is completely obstructed and cannot get into the hospitals in the District of Columbia.

THE COURT:—You don't think their action could just as reasonably be attributed to the fact that they felt after all that they should not participate in this controversy as it related to Selders?

Mr. Kelleher:—No, your Honor. Not in view of the fact—

(There was laughter in the court room.)

Mr. Kelleher:—I don't think this is a laughing matter, is it?

THE COURT:—I have asked several times and I am very much opposed not only as a matter—it doesn't comport with court procedure, laughter either during arguments of testimony, and I simply will not put up with it in future. I have made that request several times. If it occurs again among those who have been here continually, I am going to take some action. Let that be understood.

Mr. Kelleher:—Your Honor, I think—

THE COURT:—This to me is not a funny matter. It is a very serious matter. I don't know how the defendants take it. Apparently there are some very humorous things about it. Proceed.

Mr. Kelleher:—In answering your Honor's question, I think if we had only the action there, it might be susceptible to the construction which your Honor suggests, but I think in view of all of the correspondence, the correspondence between Taylor and Conklin, and then between Talley and Conklin, and then, your Honor, this letter, this reply to Columbia Hospital—that in itself is almost enough because we know that this hospital is inquiring about his standing down there; and they write back and say, "Oh, we find that if he participates in that sort of thing it is unethical."

THE COURT:—I see your viewpoint. But there is the thing that is running through my mind: When they were brought up to the consideration, up to the brink of entering into a conspiracy or into an unlawful scheme and then upon consideration see the wrongness of it or the dangers of it, if then they take action whereby they drop further consideration of it, have they gone into it; or, if so, have they withdrawn from it?

Mr. Kelleher:—I understand. I would like to meet that if I can by this: The point is they were in it. That is our conten-

tion, at least. They didn't have to go to the extent of throwing him out.

THE COURT:—If they were in it—

Mr. Kelleher:—Yes. The board of censors held him unethical. And the Harris County Society unanimously approved that action of the board of censors. Now, that is action, and that is conspiring. But let me show they did do exactly what they set out to do. They didn't have to throw him out. They adopted a less burdensome means of getting rid of him. And let me show your Honor this correspondence of West to Taylor calling attention to the provision that membership is limited to physicians who reside and practice in the counties immediately concerned. "The gentleman referred to in the correspondence"—which would mean obviously Selders—"is not in practice in Harris County. The by-laws of A. M. A. specifically provide that a member of A. M. A. who removes to another state shall forfeit membership unless within one year after the change he becomes a member of constituent association in the state to which he removes." Now, what did they do? They obtained from Selders a letter requesting his transfer. They have to do that but he is going to lose his membership. So he sends that down and they transfer. All this in the possible action of the Society furnishing the most simple and most expedient way of getting rid of that doctor.

THE COURT:—There isn't necessarily anything indicative of anything wrong in such a provision, is there?

Mr. Kelleher:—Your Honor, I think in view of all the prior correspondence on the thing—

THE COURT:—Your point is the coincidence?

Mr. Kelleher:—Yes. And I think it becomes a question of fact. Mr. Lewin points this out and I think it is a good suggestion: For one whole year, from January until November, 1938, they kept that doctor under a cloud. They declared that he was unethical. They wrote to Columbia Hospital and advised Columbia Hospital accordingly. The necessary effect of that must have been to discredit and repudiate Selders and then hinder G. H. A. in its efforts to get into the hospitals, its efforts to gain doctors with prestige. I think, your Honor, in all of those circumstances there is at least a question of fact for this jury as to whether Harris County was participating in the conspiracy.

Mr. Leahy:—If your Honor please, may I take just about five or ten minutes?

THE COURT:—Let us see if they are through. You wanted to close. I will give you a few minutes to close.

REPLY ARGUMENT ON BEHALF OF THE DEFENDANTS WILLIAM E. LEAHY

Mr. Leahy:—If your Honor please, I think the Harris County Medical Society can be disposed of rapidly. I speak for it because there is nobody here to represent the Harris County Society except ourselves sitting here at the trial table.

At the outset I want to advert to the basis of your Honor's ruling admitting in evidence certain letters. The letters were admitted upon the specific determination by your Honor that the contents of the letters, the facts contained therein, were not evidence; they were merely brought into the case in order to show that a particular defendant who received such letter had the knowledge of whatever that letter said.

When we come to the Harris County Association we have some letters which are written by Dr. Conklin to Dr. Taylor of the State Society. We have letters back and forth from Talley and Conklin, but we do not have any action taken by the Harris County Society, save and except this, that they thought—and by a vote which was taken of the body of Harris County doctors—that it was unethical for Dr. Selders to practice medicine under the scheme of G. H. A.

That is all we have in the case with regard to the Harris County Medical Society. Then when charges are preferred they think that the best procedure to take, after advising with the Judicial Council of the American Medical Association, is to drop the case entirely.

Now the point is made that they sought the transfer of Dr. Selders. They did not do any such thing. There is no evidence in this case whatsoever that anybody induced Selders to ask for a transfer. All we have is Selders' request; and the complete answer to that is this, if your Honor please, that in the letter of Dr. West to the Society calling attention to the fact that under the American Medical Association rules, if a doctor has been absent from the county in the jurisdiction of his society for a year, he is subject then to be dropped from the society or he may seek admission in some other jurisdiction where he is. The Society of Harris County accepted the back dues of Dr. Selders in full for the year of his absence, and the last entry was that Dr. Selders was a member of the Harris County Society.

They forgot to bring to your Honor's attention that when Dr. Coole was on the witness stand I asked him whether Dr. Selders was still a member of the Harris County Society, and he said yes.

That is the Harris County incident. There is no evidence whatsoever that they joined in any combination or conspiracy such as detailed in this indictment.

Mr. Kelleher:—Of course the indictment was returned on December 20, one month afterwards.

Mr. Leahy:—That is all right. But you have injected in here that he was transferred or kicked out or something. The truth of the matter is that the Harris County Society accepted his dues for the year he was absent and he is still a member of it; and there is no evidence in the case whatsoever to the contrary, except the ingenuity of counsel to try by all of their argument, which has been characteristic throughout, to ask your Honor to accept suspicion for proof; and it is only the ingenuity of counsel in raking over all this documentary evidence to inject into your Honor's mind the notion that their suspicions of what might have happened occurred, when we have the proof of what actually happened, showing that the suspicion is unjustified. So that is the Harris County case as it stands here before your Honor.

Now, let us take the case of the Academy of Surgeons. That is the other organized defendant. What do we have with reference to the Academy of Surgeons on which they ask your Honor to hold that these people who constitute the Academy of Surgeons as a separate entity was a conspirator?

They had three grounds. They stated to your Honor that in the minutes of Dec. 10, 1937 there was a statement made in the shape of the presentation of a motion that in the consideration of any applicant the ethical practice of the doctor should be considered as well as his qualifications.

What is your Honor going to draw from that? What is wrong about that? Is it wrong that a body of surgeons should say, "Here, just wait a minute. This man may be the finest surgeon in the United States and the worst abortionist"? Can they not consider that when they are considering his qualifications?

They put Dr. Fishback on the witness stand here, who was the one who sent this letter of which now they make such importance before your Honor. But let us not forget these little facts. Dr. Fishback, they said, wrote a letter to the Credentials Committee of the Academy of Surgeons on the 9th day of December 1937. I tried to jot down what the words of the letter were. He was anxious to talk with Dr. Lyons, the chairman. Not a conspirator; not mentioned as a defendant; nothing in this case to show that Dr. Lyons is anything other than the fine gentleman he is. This man, Dr. Fishback, who was on this witness stand, called as a witness for the prosecution, wrote to him and said:

"I am anxious to talk with you before you reach any decision in the application of Selders, especially if there is any feeling that he should be disapproved purely because he is a member of G. H. A."

What is the inference there? That Dr. Fishback wants Dr. Lyons to know that Dr. Selders should be given a fair investigation and that there should not enter into his approval or his disapproval any question whatsoever of his connection with G. H. A.

That must be it, or they would have asked Dr. Fishback on that stand when he was here, "What about that?" If Dr. Fishback intended what the ingenuity of counsel wants to engender in your Honor's mind now, don't worry; they would have asked Dr. Fishback and your Honor would not have to guess what it is all about. Your Honor would have evidence instead of suspicion.

What did they do? The Academy of Surgeons, composed, as I have stated, of all of the surgeons in the District of Columbia who are practicing general surgery and who must be members of the District Medical Society—that Academy which has been requested to make a report upon the qualifications, makes a report and recommends to the hospitals, Georgetown, Providence, George Washington and some more, that his qualifications are such that he should not be admitted to the hospitals, and recommends against his application.

THE COURT:—What was the application for?

Mr. Leahy:—That does not show.

THE COURT:—Was it for a particular kind of surgery?

Mr. Leahy:—I do not know. It is not in the evidence.

THE COURT:—General surgery or minor surgery, or what?

Mr. Leahy:—It is not in the evidence as to what was before them. The report was not presented. I do not know whether the folder of the Academy of Surgeons shows the report or the basis for it. It seems strange if it does not contain it, and yet they cull from the files just the letter of Fishback and a motion which was made by Dr. Segar, I think, who is not a conspirator. Not a word against him. Not any of these men who passed on the qualifications of this man is a conspirator. Dr. Fred Sanderson is not mentioned as a conspirator. Dr. Lyons is another one. Not a word against them. But because the Academy of Surgery, composed of all of the surgeons of the District of Columbia, finds upon investigation and reports back that the qualifications of Dr. Selders are not sufficient to warrant his acceptance upon the hospital staffs, therefore they say your Honor must conclude that that was something hostile and inimical, at the very foundation of the entire proceedings, and that no ground existed other than hostility to G. H. A.

Mr. Kelleher:—May I correct one thing at this time? The evidence does show that at that time he applied for major surgery and that—

Mr. Leahy:—I am not talking about that.

Mr. Kelleher:—I am talking about that letter from Fishback to Providence Hospital, which shows that he applied for major surgery and general surgery at Georgetown, and Georgetown denied him even minor surgery there, and he applied for surgery at Garfield.

Mr. Leahy:—All right. He applies for the widest type of surgical practice you could get. But what group in the District of Columbia was more qualified to pass upon such qualifications than those physicians in the District of Columbia who are practicing general surgery? I ask, if your Honor please, where could the hospitals go to get advice of that kind? What has this body of fine surgeons done to be charged as conspirators?

They did their duty. They made an investigation. They reported it. The Credentials Committee had upon it no members who are named as conspirators. They sent back their report to the different hospitals; and that is everything we have.

I submit that that does not rise to any consideration of what evidence is. It is merely suspicion engendered by the ingenuity of counsel in order to conceal what the true facts are in the case.

Mr. Lewin:—May I interrupt to say that Mr. Kelleher outlined in great detail the evidence which shows that each member of that committee was connected with this conspiracy.

Mr. Leahy:—I know all about that. I cannot go over that; I haven't the time. There is nothing in this case against either of those two defendants which arises above suspicion.

With a wave of his hand, if your Honor please, counsel just simply says that Yater, Young and Martel are all conspirators—

Mr. Kelleher:—I said that about Yater.

Mr. Leahy:—All right; Yater, then. We will come to him in a minute. Yater proposed one motion in November, and when a report came back from the Hospital Committee he said, "Let us refer this back to the Hospital Committee for further consideration." And this man is to be charged with all the knowledge of this conspiracy.

THE COURT:—What were the grounds upon which he said that?

Mr. Leahy:—Because he said at that time the report had in it something to the effect that patients of Group Health Association should be treated by hospitals, and Yater thought they ought to be treated by members of the staffs of the hospitals, and Yater says, "It doesn't appear whether they are members of the staffs of the hospitals or not"—

Mr. Kelleher:—Or might become members.

Mr. Leahy:—All right. He said, "Let us send it back." He never did a thing in reference to it. There is no evidence in this case that he did anything in reference to it, not one bit, not one whit, not one line of evidence. Again I say there is nothing in this case but suspicion.

What in the world did Dr. Martel do with reference to this conspiracy? He sat over there one day in a board meeting of the doctors' staff of Georgetown Hospital and said, "I think Dr. Scandiffio is qualified, but the hospitals think he has done something which we don't agree with."

Then they said something about every one coming to attend a meeting of the hospitals, and he said, "I don't want to go."

Therefore he is a conspirator. What kind of arguments are those, if your Honor please?

Mr. Lewin:—Would you mind reading what he said there (handing a document to Mr. Leahy)?

Mr. Leahy:—I will be glad to. Where is Yater mentioned in here?

Mr. Lewin:—Right here (indicating).

Mr. Leahy:—(reading):

"Made a motion to the effect that the recommendation of the Hospital Committee be recommitted to the committee on the ground that there seems to be no assurance that members of the staff are not already or might not become members of the staffs of local hospitals if finally adopted."

That is nothing but inference.

Mr. Lewin:—Oh, no.

Mr. Leahy:—You have had your say.

He made one motion. No action was even taken; not a word spoken outside of that motion, not a single word. If your Honor please, this thing is supposed to have stretched from January down through December 1938, two years, but when they cannot find out of the mass of this evidence and all the oral testimony a single thing that the doctor has done, except dragging it in in this fashion, it shows not the fact of his membership in the conspiracy, but that in the desperation of the prosecution they are trying to make out of it somthing that is not in it.

A number of them are in that same group. Martel is in that same group; Young is in that same group. There is nothing in this case to show that he was a member of any hospital committee. When Lyons was on the stand and he was asked with reference to this—Pardon me; I think it was Mr. Rogers—what he there said was admissible because the Doctor was a defendant, and your Honor admitted it on that ground; but before it becomes an admission against him they must first show that he entered the conspiracy. Otherwise it is not an admission against him. They cannot prove it.

Mr. Kelleher:—Do you mean that the Mattingly letter does not come in against Mattingly? That is what your argument is.

Mr. Leahy:—It is not; nothing like it. Here is a hearsay statement put into the record by Mr. Rogers. Absolutely no proof. If he was on the Hospital Committee, why did they not prove it?

Mr. Lewin:—We have proved it.

Mr. Leahy:—No, except by a hearsay statement. And then Rogers said, "I don't know when he was on the Hospital Committee." That is what Rogers said. And yet Dr. Young answered the questionnaire and he said, "Up to this time we have had no applications from any G. H. A. doctors. If there is any further information you desire I will be glad to answer."

Are those the words of a conspirator? Is your Honor going to hang a man into a conspiracy of this type and charge that man with knowledge of what went on and with the purposes outlined here because he makes that kind of a statement? Nobody would be safe under the outline that is urged by the prosecution if this were a fact.

Now we come down to those who are not members of the local society. We come down to Dr. Fishbein and Dr. Leland.

THE COURT:—You have five more minutes, Mr. Leahy.

Mr. Leahy:—May I call your Honor's attention to this. There is not a single line of evidence brought to your Honor's attention yet about Leland; not one. The only evidence which they brought was a letter, and in that letter Leland had proposed that the Society should form an organization of its own. There is not a line of testimony against Leland. Everything that was read to your Honor was written by somebody else. In every one of those letters there is not a single line against Leland. There is not a single line against Fishbein; and it cannot be charged that because an article is published in THE JOURNAL therefore Dr. Fishbein is to be charged with everything else that was done after that article was published.

I still say, in all of the time which was taken, two and a half hours, they have not brought to your Honor's attention any real evidence against any of these defendants, either corporate, association or individual, which I brought to your Honor's attention this morning. It does not rise above suspicion.

Secondly, the proof upon which they rely is to be found written in letters by others which your Honor admitted not as proof of the facts contained therein, because they are pure hearsay, but only and solely for what the person who received the letter may have known of the contents thereof.

Leland never received one and he never wrote one. The same is true with reference to Dr. Fishbein.

I respectfully submit that there is not anything which can possibly connect those defendants in any way with this conspiracy.

(To be continued)

MEDICAL LEGISLATION

MEDICAL BILLS IN CONGRESS

Change in Status.—H. R. 2082 has passed the House, proposing to empower the Secretary of the Interior, acting through the United States Bureau of Mines, to make annual or necessary inspections and investigations in coal mines to obtain information relating to health and safety conditions, accidents and occupational diseases therein.

Bills Introduced.—S. 985, introduced by Senator Russell, Georgia, proposes to amend the Selective Training and Service Act by providing that members of local boards and physicians and other persons who rendered services in connection with the work of such boards and whose compensation for such services is not otherwise provided for shall receive compensation at the rate of $4 a day for the time actually spent by them in conducting or assisting in the work of the boards. S. 987, introduced by Senator Gurney, South Dakota, provides that any student who has heretofore sustained or who hereafter sustains a personal injury while engaged in receiving flight instruction under the civilian pilot training program provided for by the Civilian Pilot Training Act of 1939 shall receive such hospitalization and medical treatment as is provided for any officer of the Air Corps of the Army of the United States who receives a personal injury in line of duty. H. R. 3570, introduced by Representative Lanham, Texas, proposes a federal appropriation of $150,000,000 for providing additional community facilities made necessary by national defense activities. This money, it is proposed, will be expended in accordance with such directions and regulations and on such terms and conditions as may be prescribed or approved by the President (*a*) to make loans or grants or both to public agencies for the construction, rehabilitation and operation of such facilities; (*b*) to construct, operate, lease or sell such facilities, including the acquisition of land and the demolition, repair or alteration of existing structures where necessary, and (*c*) for necessary administrative expenses. In a hearing before the House Committee on Public Buildings and Grounds the Assistant Coordinator of Health and Welfare and Related Defense Activities testified that out of the total appropriation to be authorized $25,000,000 would be used for the construction of hospitals and $4,200,000 for the construction of clinics. Furthermore, $2,200,000 will be used for grants for hospital care of transient indigents, $2,800,000 for grants for ambulatory care of transient indigents and $1,000,000 for grants for hospital operation. H. R. 3778, introduced by Representative Mundt, South Dakota, proposes to create a Division of Water Pollution Control in the United States Public Health Service. H. R. 3928, introduced by Representative Mundt, South Dakota, proposes an appropriation of $1,000,000 to construct a veterans' hospital in the First Congressional District of South Dakota.

STATE MEDICAL LEGISLATION

Arizona

Bills Introduced.—S. 151, to amend the workmen's compensation acts, proposes that an injured employee may elect to be attended, at the expense of the state fund, by a licensed chiropractor, osteopath, naturopath or other practitioner of drugless methods and thereafter is to be entitled to the benefits of the act to the same extent as if he had been attended by a licensed practitioner of medicine and surgery. The bill further proposes that, in connection with the provisions of the workmen's compensation act, licensed chiropractors, osteopaths, naturopaths and other practitioners of drugless methods are to be accorded equal rights and privileges with licensed practitioners of medicine and surgery by the industrial commission, by all public agencies, institutions, officers and employees and that the discrimination against any licensed drugless practitioner in this respect shall automatically cause the holder of any public employment or public office causing, permitting or participating in any such discrimination to forfeit his office or employment. H. 205 proposes to prohibit the maintenance and operation of a maternity hospital unless licensed by the state board of health.

Delaware

Bill Introduced.—H. 237 proposes to enact a separate practice act for dispensing opticians and to authorize the Medical Council of Delaware to examine and license applicants for licenses to practice as dispensing opticians. The bill proposes that "Individuals and firms filling prescriptions of physicians and surgeons licensed by the Medical Council of Delaware for ophthalmic lenses and kindred products, and as incidental to the filling of such prescriptions, taking facial measurements and fitting and adjusting lenses or frames, shall be known as dispensing opticians." The bill further proposes that it shall not affect any person licensed as an optometrist or a physician and surgeon but that this exemption shall not apply to any optometrist or a physician exclusively engaged in the business of filling prescriptions for physicians and surgeons.

Illinois

Bills Introduced.—S. 15 and H. 86 propose that "If it is alleged in the indictment or information, or upon the trial, that the defendant was under the influence of intoxicating liquor when he drove a vehicle, the court may admit evidence of the amount of alcohol in the defendant's blood at the time alleged, as shown by a chemical analysis of his urine, saliva, breath, or other body substance." S. 103 proposes to make it unlawful for any person to use the designation "Certified Consulting Psychologist" or any similar term unless he has been licensed so to practice by the Department of Registration and Education. No person shall be eligible for such a license unless, among other things, he has received a degree of doctor of philosophy in psychology or of doctor of science in psychology from a college or university approved by the department, or a degree of doctor of education or doctor of philosophy in education from a school or university also approved by the department and he has also had two years' experience in the application of the principles and technics of the science of psychology.

Kansas

Bills Introduced.—H. 143 proposes to authorize the governing body of any city of the second class having a population of not less than five thousand nor more than eight thousand and located in a county having a population of not less than eleven thousand nor more than fourteen thousand to issue bonds in the city in an amount not exceeding one hundred thousand dollars to build and equip a municipal hospital. The governing body of such a city is to have the power to rent, lease or let such hospital to any person or corporation on such terms and conditions as the governing body deems to the best interests of the city. H. 367 proposes to authorize the governing body of any city of the second class located in a county having a population of not less than fourteen thousand nor more than eighteen thousand and having an assessed tangible valuation of not less than twenty-five million dollars nor more than thirty-five million dollars and having within its boundaries two or more cities of the second class to issue the bonds of such city in an amount not exceeding thirty thousand dollars to construct and equip a municipal hospital. The governing body of such a city is to have the power to lease, let or rent said hospital to any person or corporation on such terms and conditions as it sees fit.

Massachusetts

Bills Introduced.—H. 1018 proposes that the physical examination given school children shall include an examination of the feet given by a person well qualified to examine feet. H. 1564, to amend the medical practice act, proposes that the board of registration in medicine in its examinations of applicants shall have requirements "at least as qualifying as the standards of admission recommended by the national board of registration in medicine."

Michigan

Bill Introduced.—H. 209 proposes to repeal the basic science act.

Nevada

Bill Introduced.—A. 121 proposes to condition the issue of a license to marry on the presentation by each party to the proposed marriage of a certificate of a licensed physician that the party has been given such examination, including a standard serologic test, as may be necessary for the discovery of syphilis, made not more than thirty days prior to the issuance of a license and that in the opinion of the physician the party either is not infected with syphilis or, if so infected, is not in a stage of that disease which is or may become communicable to the marital partner. The charge for the physical examination and certificate of the physician is not to exceed $5.

New Mexico

Bills Introduced.—S. 216 proposes to authorize the county commissioners of the several counties to established county hospitals in their respective counties. H. 210 proposes that "The right to choose and designate one's own physician or surgeon is hereby declared an inviolate right. Except in workmen's compensation cases and in such other cases where medical care and consultation is provided without obligation on the part of recipient to pay therefor, no person living or residing in the state of New Mexico shall be compelled, coerced or intimidated in contracting for, procuring or accepting the services or professional care of any particular physician or surgeon or the care or services of any physician or surgeon of any particular school, class or association."

New York

Bills Introduced.—S. 1103 and A. 1426, to amend the medical practice act, proposes to exempt from its provisions "any physician or surgeon employed in the United States veterans' administration while engaged in the performance of the actual duties prescribed for him under the United States statutes." A. 1231 proposes to create a temporary state commission to study and investigate the system of physical education and medical inspection in the public schools, to make recommendations for the carrying out of a physical education and medical inspection program which would adequately equip the youth to be in physical condition.

North Carolina

Bill Introduced.—H. 372 proposes to authorize the State Commission for the Blind to employ reputable optometrists to provide the services, "provided, however, nothing in this section shall authorize the employment of optometrists in work under supervision of the Federal Social Security Board which would affect federal grants to the state of North Carolina for aid to the needy blind."

Ohio

Bills Introduced.—S. J. Res. 15 proposes to require the presiding officers of the house and the senate to appoint a commission to hold public hearings, to make investigations of the health laws of the state and to report to the general assembly its findings and such recommendations as it may make for their more efficient administration. H. 217 proposes to condition the issuance of a license to marry on the presentation by each party to the proposed marriage of a physician's certificate that the party has been examined within fifteen days prior to the application and that in the opinion of the physician the party is free from epilepsy, feeblemindedness and insanity and is not infected with syphilis or is not in a stage of that disease which may become communicable, as nearly as these facts can be determined by examination of the party and by the application of standard laboratory tests for syphilis.

Oklahoma

Bills Introduced.—S. 163 proposes to authorize the creation of a county health unit in each county of the state, or a district unit, to be composed of a number of contiguous counties, the purpose of which is to promote the public health by education, training and the administration of preventive medicine, in cooperation and active participation of the state board of public health. The health units provided for in the bill are to be confined to the field of preventive medicine, "except in the case of patients afflicted with venereal disease, which may be treated by said unit only when properly certified to the director by a doctor who is licensed to practice medicine or osteopathy, under the laws of this state, and under such regulations as may be prescribed by the state board of public health and United States Public Health Service." H. 297 proposes that "Any doctor, licensed and authorized to practice the medical profession in the state of Oklahoma, shall, upon request, respond and act professionally when called in any emergency." The bill proposes to define emergency as any childbirth case, or in case of a request for setting a broken bone, or a cut wound or bruise in case of injury or accident, needing immediate attention. If the patient fails for one year to pay the physician, the physician shall file a claim with appropriate county, which is required to pay the physician the usual fee for such services.

Pennsylvania

Bills Introduced.—S. Serial No. 30 proposes "That the senate of the general assembly of Pennsylvania request the secretary of public assistance to equitably revise the determinants guiding the prorating of fees payable to physicians attending recipients of assistance, as well as expedite the payments of amounts now due to such physicians." H. 537 proposes that any state or state-aided medical and surgical hospital shall have authority to issue stamps and to place any such stamps on sale. These stamps are to be redeemable by the hospital issuing them through hospitalization service. H. 555 proposes a procedure for the reimbursement of all hospitals not now receiving state aid for the expenses of indigent persons injured in motor vehicle accidents. H. 559 proposes to create the Pennsylvania State Institute for Cancer and Tuberculosis Research to conduct a study of and research into the causes, treatment and prevention and cure of cancer and tuberculosis.

Texas

Bills Introduced.—S. 214 proposes to make it the duty of the state department of health to enter into agreements with all licensed practitioners of medicine and dentistry in the state who are willing to agree to receive as patients and to treat destitute children, in accordance with the needs of such patients, at fees to be determined as provided in the act, to be payable to such physicians by the state. The schedule of fees is to be made in accordance with the recommendations of the State Medical Association of Texas and the Texas State Dental Society. H. 268 proposes to authorize the establishment and operation of a state cancer hospital.

Utah

Bill Introduced.—H. 168 proposes that the body of a person whose death occurs in the state shall not be removed to any autopsy room or to any place where embalming is done, nor shall any mutilation of any kind be permitted, until the body has been subjected to scientific life tests to determine whether or not death is complete. The nature and character of such life tests are to be ascertained from year to year by the head of the state board of health from the tests advocated by the American Medical Association and the National Selected Morticians. Such tests are to be administered by a physician or by a board of health medical employee at least four hours after death.

Washington

Bills Introduced.—H. 504 proposes to authorize corporations organized under the general laws of the state to transact a hospital association business if licensed by the insurance commissioner. The bill states that a hospital association business is carried on by any corporation, association or person "contracting or agreeing in this state with individuals, families, employees, associations, societies or with employers for the benefit of employees, for the furnishing of medicine, medical or surgical treatment, nursing, hospital service, ambulance service, dental service; or any or all of the above enumerated services or any other necessary services, contingent upon sickness, or accident."

Wisconsin

Bills Introduced.—A. 319 proposes that, whenever expert medical testimony becomes necessary or desirable in the establishment of the claim of an employee in connection with a claim

under the workmen's compensation act, the industrial commission may, after notice to the parties and a hearing, permit one or more qualified physicians, not exceeding three, to testify for the employee at the trial. The compensation of such medical witnesses is to be fixed by the commission. A. 334 proposes that the state board of examiners in chiropractic may issue license without examination to any applicant who presents proof that he has been licensed to practice chiropractic in another state and has practiced for three years or more, if, in the state or states in which the applicant has so practiced, preliminary education which is not less than that required in the state is required.

OFFICIAL NOTES

RADIO BROADCASTS

The next three programs to be broadcast in the series "Doctors at Work" are as follows:

March 26. Health for the Workman.
April 2. Invisible Invaders.
April 9. The Life Ray.

The program is scheduled over the Blue network of the National Broadcasting Company Wednesdays at 10:30 p. m. eastern standard time (9:30 central, 8:30 mountain, 7:30 Pacific time).

Tickets for the broadcasts are available. Requests should be accompanied by a stamped addressed envelop.

WOMAN'S AUXILIARY

Minnesota

The Woman's Auxiliary to the Olmsted-Houston-Fillmore-Dodge Counties Medical Society held a meeting, January 8, in Rochester. Dr. F. M. Feldman, director of District 3, Minnesota Department of Public Health, and deputy health officer of Rochester, spoke on the undesirable housing conditions of Rochester. The St. Louis County auxiliary held its monthly meeting, January 14, at the home of the president, Mrs. W. N. Graves, Duluth. After the business meeting the members did Red Cross work. The chief project of the auxiliary this year is the furnishing of the patients' sitting room at the Nopeming Sanatorium.

New York

The executive board of the woman's auxiliary to the Medical Society of the State of New York met recently at Garden City, L. I., with thirty-seven members attending. The board members were guests in the homes of members of the Nassau County auxiliary. The evening preceding the meeting a dinner was given for them by the president of the state auxiliary, Mrs. Luther H. Kice. Dr. Louis H. Bauer, a member of the preparedness committee of the state medical society, gave a talk on auxiliary preparedness. In the evening, the auxiliary to the Nassau County Society entertained at the Hempstead Country Club.

The Montgomery County auxiliary was organized recently. Mrs. Luther H. Kice, state auxiliary president, explained the purpose of an auxiliary. Mrs. J. P. Curran was selected as the chairman of a committee to draw up a constitution. Those attending from organized counties were Mrs. Kice of Garden City, Mrs. A. W. Greene, Mrs. W. F. MacDonald, Mrs. A. H. Cougdon and Mrs. L. P. Tischler of Schenectady and Mrs. R. F. Johnson and Mrs. G. C. Sincerbeaux of Auburn.

At their first meeting, November 1, the following officers were elected: president, Mrs. S. L. Hounrighouse; president-elect, Mrs. P. J. Fitzgibbons; vice president, Mrs. W. H. Seward; secretary, Mrs. E. B. Kelly, and treasurer, Mrs. A. J. Tounley of Fonda.

Oregon

The auxiliary to the Multnomah County Medical Society met, December 9, at the Albertina Kerr Nursery Home for its annual children's party. Gifts were distributed from a Christmas tree. Mrs. Albert H. Cautril and Mrs. Charles H. Manlove spoke in behalf of the student loan fund, a project of the auxiliary. New loans to the amount of $1,000 have been made this year to seniors in the medical school; there are three students on the waiting list. Twenty-two hundred dollars in a revolving fund is gradually being repaid. To date forty-two seniors and juniors have been aided. Miss Nell Under, librarian for the Library Association of Portland, spoke on "Reading for Pleasure" to the thirty-five members present. Volunteers from this auxiliary assisted, November 16, in the Red Cross drive, taking over booths for a half a day in banks and department stores. Six members of the junior auxiliary, an organization of wives of medical students, also assisted. Volunteers sew one day a week at the Red Cross headquarters.

At the November meeting of the woman's auxiliary to the Marshfield, Coos and Curry Counties Medical Society, Mrs. A. B. Peacock talked about her visit to the Basque Colony in eastern Oregon.

Texas

The auxiliary to the Cherokee County Medical Society met recently at the Doctors' Home at Rusk State Hospital. Fourteen members and one guest were present. The program was based on material in *Hygeia*.

The auxiliary to the Childress-Callingsworth-Hall Counties Medical Society met with the medical society recently at a dinner. The auxiliary voted to sponsor an essay contest in all high schools in the three counties on the subject "Increasing the Span of Life" and to give several prizes.

The auxiliary to the Tom Green Eight County Medical Society met recently in San Angelo with members of the city federated clubs, Parent-Teacher Association and interested citizens as guests. Dr. Carl A. Kunath spoke on "Importance of the Periodic Health Examination in the Control of Cancer."

The auxiliary to the Lampasas-Burnet-Llana Counties Medical Society honored medical societies of the same counties with a fish fry recently.

Washington

The auxiliary to the King County Medical Society met, January 21, in Seattle with fifty members in attendance. Mrs. W. A. Willington presided. Mrs. Shelby Jared, legislative chairman, presented Dr. Frank Douglass, who spoke on "Important Legislative Messages." It was reported that three hundred and twenty subscriptions had been obtained for *Hygeia*.

The Pierce County auxiliary had forty members present at the January meeting in Tacoma at the home of Dr. and Mrs. Leo Hunt. The president, Mrs. J. B. Robertson, presided. Major Kenneth A. Whyte of the 116th Medical Regiment of Camp Murray talked on medical preparedness.

Ten members were present at the January meeting of the Chelan County auxiliary in Wenatchee. Mr. Giberson of the state health department spoke on "Sanitation and Health."

Twenty-eight members were present at the January meeting of the Spokane County auxiliary at the University Club. Dr. John O'Shea, a member on the National Medical Preparedness Committee, the guest speaker, told of the part that the American Medical Association is taking in national defense. Mrs. George Ford told of the work of the Canadian women in the Red Cross. The legislative chairman, Mrs. Clarence Lyon, informed the group of pending bills before Congress and the state legislature in regard to medicine. Fifteen dollars was voted to place *Hygeia* in the public schools.

The Grays Harbor County auxiliary met in January at the home of Dr. and Mrs. B. O. Swinehart in Aberdeen. Fourteen members were present. The auxiliary voted to subscribe to the National Bulletin.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST; SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

ADDITIONAL MEDICAL COLLEGE NEWS AND ARTICLES APPEAR IN THE STUDENT SECTION, PAGE 1325.

ARKANSAS

Personal.—The new county health building at Pine Bluff has been named the W. H. Bruce Building in recognition of the work of Dr. Bruce in Jefferson County. Dr. Bruce is city and county health officer.——Dr. Armour K. Wayman, Little Rock, has been appointed superintendent of the Pulaski County Hospital.——Dr. Ralph E. Weddington, Fort Smith, has been appointed health officer of Independence County, succeeding Dr. Gardner H. Landers, Batesville, who resigned to join the military forces.——Dr. Frank C. Maguire, Clarendon, has been named director of the Mississippi County health unit.

CALIFORNIA

Lectures for the Public.—The fifty-ninth course of popular medical lectures sponsored by Stanford University School of Medicine, San Francisco, will be presented at Lane Hall by:

Dr. John H. Lawrence, April 4, The Cyclotron in Cancer Research.
Dr. Merlin T. R. Maynard, April 18, Cosmetics and Care of the Skin.
Dr. David A. Rytand, May 2, The Newer Knowledge About High Blood Pressure.
Dr. Hale F. Shirley, May 16, Changing Attitudes in Child Guidance.

Personal.—Alden H. Miller, Ph.D., associate professor of zoology and director of the museum of vertebrate zoology, University of California, Berkeley, has been elected a corresponding member of the Zoological Society of London.——Dr. Henry E. Dahleen has been appointed superintendent of the Santa Clara County Hospital, San Jose, succeeding Dr. Doxey R. Wilson.

CONNECTICUT

Physicians Honored.—Seven physicians who have completed fifty years in the practice of medicine were guests at a dinner recently in Derby, attended by physicians, nurses, hospital board members and their families in the community comprising Shelton, Derby, Ansonia and Seymour. Their names are Drs. Edward K. Parmelee and Henry Steudel, Ansonia; William Sherman Randall, Shelton; Frank N. Loomis, Royal W. Pinney, Charles T. Baldwin, Derby, and Louis E. Cooper, New Haven.

Society News.—The Yale Medical Society was addressed at the Brady Memorial Laboratory, New Haven, February 12, by William U. Gardner, Ph.D., on "Breaking Strength of Bones of Mice Receiving Sex Hormones"; Dr. William Metcalf, "Fat and Effects of Transfused Serum"; Adolf Pharo Gagge, Ph.D., "A Method for the Continuous Measurement of Metabolic Rate During Work," and Drs. Alexander W. Winkler, Hebbel E. Hoff and Paul K. Smith, Ph.D., "Cause of Death in Experimental Anuria." All are of New Haven.

DELAWARE

Society News.—Dr. Edward Weiss, professor of clinical medicine, Temple University School of Medicine, Philadelphia, addressed the New Castle County Medical Society in Wilmington, January 21, on "Illness of Emotional Origin and Its Treatment by the General Practitioner."——The Biochemical Research Foundation, Newark, presented its annual biochemical research lecture recently at the University of Delaware with Prof. Henrik Dam, Biochemical Institute, University of Copenhagen, as the speaker. The subject was "The Present State of Knowledge of Vitamin K."

DISTRICT OF COLUMBIA

The Kober Lecture.—John R. Mohler, D.V.M., chief of the bureau of animal industry, U. S. Department of Agriculture, will deliver the Kober Memorial Lecture, March 28, under the auspices of Georgetown University. His subject will be "Undulant Fever." The lecture is delivered under rules governing an endowment fund established by the late Dr. George M. Kober. Dr. Mohler received his degree in veterinary medicine at the University of Pennsylvania in 1896. He has been awarded many honorary degrees, is a member of several scientific societies and was president of the American Veterinary Medical Association in 1913.

Postgraduate Clinic.—The ninth annual postgraduate clinic of the George Washington University School of Medicine was held on February 14-15 with Dr. Harry F. Dowling, clinical professor of medicine, as director. The program this year was dedicated to Dr. William Johnston Mallory, professor emeritus of medicine. The evening meetings were under the auspices of the A. F. A. King Obstetrical [redacted], named in honor of an alumnus of George Washington [redacted] died Dec. 13, 1914, and who served on its staff as profe[redacted] of obstetrics and diseases of women and children from 18[redacted] to 1913 and as dean from 1879 to 1894. Speakers included:

Dr. Louis H. Douglass, Baltimore, Toxemias of Pregnancy.
Dr. Morris Edward Davis, Chicago, Physiology, Chemistry and Clinical Application of the Estrogens.
Dr. Robert A. Ross, Durham, N. C., Management of Uterine Prolapse.
Dr. Tom D. Spies, Cincinnati, Clinical Aspects of Nutritional Diseases.
Dr. Charles Stanley White, Washington, Use of Plasma in Surgery.
Dr. Charles W. Mayo, Rochester, Minn., Diseases of the Colon.

Dr. Paul D. White, Boston, conducted a clinic on heart diseases Saturday afternoon.

FLORIDA

Personal.—Dr. Walter L. Shackelford, West Palm Beach, resigned as superintendent of the Good Samaritan Hospital, effective February 1, to enter private practice. He had been superintendent of the hospital for thirteen years.——Dr. John O. Barfield, formerly of Miami and Apalachicola, has been appointed director of the city-county health department at Panama City.

New State Health Officer.—Dr. William H. Pickett, Jacksonville, assistant state health officer, has been appointed state health officer to fill the unexpired term of Dr. Albert B. McCreary, who died on January 24. Dr. Pickett's position as assistant state health officer was created last year on the recommendation of the American Public Health Association following a survey of the health situation in Florida. Dr. Pickett graduated at the Atlanta School of Medicine in 1911. His public health career includes two years as health officer of Pinellas County, two as health officer in Escambia County and eleven years as health officer first of Saginaw City and later of Saginaw County, Mich. He was also health commissioner of Great Falls, Mont., and deputy state health commissioner for Missouri. Dr. James N. Patterson, Jacksonville, director of the bureau of laboratories since 1938, has been named assistant to Dr. Pickett. He will continue to direct the laboratories. He graduated at the University of Cincinnati College of Medicine in 1929.

GEORGIA

Training School for Study of Malaria.—The U. S. Public Health Service and the state department of health cooperated in a two weeks course recently to train laboratory technicians in the preparation, staining and examination of thick and thin blood films for malaria parasites. The course opened on March 3 under the supervision of Miss Aimee Wilcox of the National Institute of Health, and classes were held in the Atlanta laboratories of the state department of health.

Honorary Certificates Awarded.—Three physicians were awarded honorary membership in the Fulton County Medical Society recently for having been members of the society for twenty-five consecutive years and for having reached the age of 65. The physicians are Drs. William Troy Bivings, who graduated at University and Bellevue Hospital Medical College, New York, in 1899 and who has practiced in Atlanta since 1903; Thomas J. Collier, who graduated at Atlanta College of Physicians and Surgeons in 1900 and who has practiced in Atlanta since 1900; Emmett DeWitt Highsmith, who graduated at Atlanta College of Physicians and Surgeons in 1906 and who practiced in Atlanta from 1906 to 1939, when he retired on account of his health. Dr. Collier is vice chairman of the recently organized Section on Anesthesiology of the American Medical Association.

ILLINOIS

Mr. Brandon Heads Department of Public Welfare.—Rodney H. Brandon, Batavia, was recently appointed director of the state department of public welfare, a position he occupied from 1929 to 1933. He succeeds Charles E. Day, resigned. Since 1933 Mr. Brandon has been a lecturer in criminology,

social hygiene and medical jurisprudence at the University of Illinois College of Medicine, Chicago. He has also been serving as a member of the board of public welfare commissioners.

Society News.—Dr. Reno P. Rosi, Springfield, pneumonia control officer of the state department of health, discussed diagnosis and treatment of pneumonia before the Madison County Medical Society at Granite City, March 7.——Joseph H. Roe, Ph.D., Washington, D. C., discussed "Diagnostic Significance of Chemical Changes in the Blood" before the Peoria Medical Society, March 5.——Dr. Guy S. Van Alstyne, Chicago, discussed "Biliary Tract Surgery" before the Rock Island County Medical Society in Rock Island, March 11.

Chicago

Study of Facial Abnormalities.—Northwestern University has received $50,000 from the Clara A. Abbott trust for the study and treatment of harelip, cleft palate and similar facial or oral abnormalities. The study will be under the direction of Dr. Frederick W. Merrifield of the medical and dental faculties, newspapers announced. The university previously received $1,665,000 from the Abbott trust, which was set up under the will of the widow of Dr. Wallace C. Abbott, founder of the Abbott Laboratories.

Dr. Bucy Joins Illinois Faculty.—Dr. Paul C. Bucy, associate professor of surgery (neurosurgery), University of Chicago, the School of Medicine, has been appointed associate professor of neurology and neurologic surgery at the University of Illinois College of Medicine. He will be associated with Dr. Eric Oldberg, professor and head of the department of neurology and neurologic surgery in the recently completed Neuropsychiatric Institute on the Chicago campus of the University of Illinois. Dr. Bucy graduated at the State University of Iowa College of Medicine in 1927 and had been on the staff of the University of Chicago since 1928. He was secretary of the Section on Nervous and Mental Diseases of the American Medical Association from 1936 to 1939 and chairman of the section, 1939-1940.

Society News.—Dr. William S. Middleton, Madison, Wis., addressed the Society of Medical History of Chicago February 25 on "Medicine at Valley Forge."——The Chicago Orthopedic Society was addressed, February 14, by Drs. Albert C. Schmidt, Milwaukee, on "Fractures in Children" and Ralph M. Carter, Green Bay, Wis., "Unusual Deformity of Wrist."——Members of the department of ophthalmology of Northwestern University Medical School presented the program before the Chicago Ophthalmological Society, February 17; the speakers were Drs. Edward V. L. Brown on "Retroretinal Tissue from the Choroid in Kuhnt-Junius Degeneration"; Bertha A. Klien, "Detachment of the Pars Ciliaris Retinae: A Clinical Finding of Differential Diagnostic Value in Retinal Detachment," and Percy F. Swindle, Ph.D., Milwaukee, "Morphology and Function of the Scleral Vessels."——Dr. Philip Lewin, among others, discussed "Low Back Pain and the Sciatic Syndrome" before the Chicago Roentgen Society, February 17, and Dr. William Edward Chamberlain, Philadelphia, "The Roentgenologist's Part in the Problem of Low Back Pain."

Noise Reduction Council Formed.—The Chicago Noise Reduction Council was organized at a meeting in the Bismarck Hotel, March 11. The council is the result of a movement begun last year when a group of national manufacturers held a conference in Buffalo and formed the National Noise Abatement Council. Mr. F. Edgar McGee of Remington Rand, Inc., Buffalo, is the executive secretary of the national agency, and Mr. George P. Little of the Celotex Corporation, Chicago, chairman. At meetings in Chicago in November and in New York in January a program on ways and means was set up on a temporary basis for the national group. A permanent organization has been effected and headquarters will be established in Cleveland, where on March 18 a meeting of representatives of interested groups throughout the country was held. Directors of the Chicago Noise Reduction Council include Karl Eitel, head of the Bismarck Hotel, chairman; Jules E. Jenkins, president of the Vibration Measurement Engineers, secretary; Fred M. Echoff of Remington Rand, Inc.; Marshall Solberg, attorney, and G. L. Bostwick, manager, sales department, U. S. Gypsum Company.

INDIANA

Changes in Health Officers.—Dr. Robert M. Ferguson, Indianapolis, has been named director of health district number 4 with headquarters in Rising Sun. He succeeds Dr. George M. Brother, who is now chief of the bureau of local health administration, Indianapolis. District number 4 includes the counties of Dearborn, Ripley, Jefferson, Switzerland and Ohio. Dr. Wesley M. Hall, Rising Sun, has been appointed to succeed the late Dr. George H. Hansell as health commissioner of Ohio County.

IOWA

Society News.—Dr. Clifford J. Barborka, Chicago, discussed "Nutrition and Subclinical States of Deficiency Diseases" before the Linn County Medical Society in Cedar Rapids on March 13. Dr. Oscar W. Bethea, New Orleans, discussed "Bronchiectasis," February 9.——Dr. Raphael Isaacs, Chicago, addressed the Boone and Story County medical societies in Ames recently on "Diagnosis and Treatment of Common Types of Anemia."——Dr. Frank R. Peterson, Iowa City, discussed diseases of the gallbladder before the Scott County Medical Society in Davenport, February 4.

Annual Meeting on Tuberculosis.—The twenty-sixth annual meeting of the Iowa Tuberculosis Association will be held at the Fort Des Moines Hotel, Des Moines, March 27-28. On the program will be the following out of state speakers: Drs. Henry C. Sweany, Chicago, "Trends During the Past Decade in the Management of Tuberculosis"; Lewis S. Jordan, Granite Falls, Minn., "Finding the Source and Breaking the Contact"; William H. Oatway Jr., Madison, Wis., "Tuberculosis Case-Finding Results Among Hospital Entrants and Personnel," and Charles E. Lyght, Northfield, Minn., "A Challenge to Iowa Colleges."

KANSAS

Personal.—Dr. Clayton L. Scuka has been appointed superintendent of the Sedgwick County Hospital in Wichita, succeeding Dr. Otto F. L. Prochazka, who resigned to serve a year in the army at Fort Robinson, Ark.

Society News.—Dr. Wade H. Miller, Kansas City, Mo., discussed "Various Problems in Aviation Medicine" before the Shawnee County Medical Society on March 3 in Topeka. Dr. Hiram Winnett Orr, Lincoln, Neb., discussed "The Role of Sulfanilamide and Other Antiseptics in the Treatment of Wound Infections and Compound Fractures" before the society, February 3.——Dr. Richard K. Gilchrist, Chicago, addressed the Sedgwick County Medical Society, February 18, in Wichita on "Method of Spread of Carcinoma, with Particular Attention to the Large Bowel."

MARYLAND

Dr. Loewi Delivers Dohme Lectures.—Dr. Otto Loewi, research professor of pharmacology, New York University College of Medicine, New York, delivered the Dohme Lectures for 1940-1941 at the Johns Hopkins University School of Medicine, Baltimore, January 21-22. His subject was "Humoral Transmission of Nervous Impulse."

Medical and Public Health Laboratories.—The midwinter conference of the Maryland Association of Medical and Public Health Laboratories was held in Baltimore, February 14. The following spoke:

Mr. A. A. Hajna and Cornelius A. Perry, Sc.D., Bacteriologic Examinations for Enteric Pathogens.
Dr. Milton S. Sacks, Diagnosis of Infectious Mononucleosis by Blood Smears and Agglutination Tests.
Dr. Samuel T. Helms, Tests for the Control of Chemotherapy.

MASSACHUSETTS

Dr. Goodpasture Delivers Cutter Lecture.—Dr. Ernest W. Goodpasture, professor of pathology, Vanderbilt University School of Medicine, Nashville, Tenn., delivered the Cutter Lecture on preventive medicine at Harvard Medical School, Boston, Friday, March 7. The subject of the lecture was intracellular infection.

Society News.—Dr. Walter Gray Phippen, Salem, president of the Massachusetts Medical Society, discussed "Medical Preparedness" before the New England Society of Physical Medicine in Boston, February 19.——The Worcester District Medical Society devoted its meeting, February 12, to a round table discussion on neuropsychiatric disorders in relation to military service: the speakers were Drs. Morgan B. Hodskins, Palmer; William Malamud, George A. MacIver, William L. Holt Jr. and Mr. David Shakow, all of Worcester.

MICHIGAN

Graduate Conferences.—The annual spring graduate conferences for physicians, sponsored by the Wayne County Medical Society and the Detroit Department of Health, will be held at Herman Kiefer Hospital, April 9, 16, 23 and 30. The last one will be a joint program with the pediatric group.

New Appointments at Wayne.—Recent additions to the faculty of Wayne University College of Medicine, Detroit, include Drs. Carl C. Pfeiffer, associate professor of pharmacology; Mark E. Maun, assistant professor of pathology; George L. Maison, assistant professor of physiology, and Lawrence Berman, assistant professor of pathology.

Courses for Graduates.—Announcement is made in the state medical journal of a series of courses for graduates in medicine. The courses will be held in Detroit and Ann Arbor and will run through the summer months. An extramural postgraduate course will begin March 24 to continue through April 18 in Ann Arbor, Battle Creek, Kalamazoo, Flint, Grand Rapids, Lansing, Jackson, Mount Clemens, Saginaw, Traverse City, Manistee, Cadillac and Petoskey. Complete details may be obtained from the Department of Postgraduate Medicine, 1313 Ann Street, Ann Arbor.

Annual Clinic Day.—St. Mary's Hospital, Detroit, observed its annual clinic day March 20. The program included a series of clinical panel discussions in the morning. In the afternoon the Theodore A. McGraw Memorial Lectures were delivered by James A. Reyniers, M.S., associate professor and head of the bacteriology laboratories, Notre Dame University, South Bend, Ind., on "Nutrition in the Newborn Germ-Free Animal," and Dr. Henry N. Harkins, Detroit, "Treatment of Shock in Wartime with a Report of the Latest Work of the National Research Council Preparedness Committee on Shock." Alphonse M. Schwitalla, S.J., dean, St. Louis University School of Medicine, St. Louis, gave an address in the evening.

MINNESOTA

Memorial to Dr. Rypins.—Dr. Luigi Luzzatti has been announced as the first incumbent of the Harold Rypins research assistantship in pediatrics at the University of Minnesota Medical School, Minneapolis, according to *Minnesota Medicine.* The position was established by a committee of Twin City physicians and other interested persons in honor of the late Dr. Rypins, who was instructor in medicine at the university from 1920 to 1923. At the time of his death in 1939 Dr. Rypins was secretary of the New York State Board of Medical Examiners. Dr. Luzzatti graduated at the University of Rome, Italy, in 1937.

County Officers' Meeting.—The annual county officers' meeting of the Minnesota State Medical Association was held at the St. Paul Hotel, St. Paul, February 22. Military medical problems were discussed by Lieut. Col. Richard B. Hullsick, director, medical division of the selective service system, and Major Frederick S. Richardson, surgeon of the first military area. Mr. John B. Pratt, Chicago, executive secretary of the National Physicians Committee for Extension of Medical Service, addressed the luncheon session on "Control and Direction of Medical Service." Justice Royal B. Stone discussed obligations and responsibilities of the doctor in court and particularly the work of the committee on medical testimony. This committee was appointed by the state medical association late in 1940 to be at the disposal of any judge in the state who has reason to believe that medical testimony in a case decided in his court has deliberately deviated from the truth. If, after investigation, the committee decides the testimony was dishonest the case will be turned over to the state board of medical examiners. A similar committee was appointed by the state bar association.

MISSOURI

The Carman Lecture.—The annual Russell D. Carman Lecture will be presented under the auspices of the St. Louis Medical Society on March 25. The speaker will be Dr. Byrl R. Kirklin, Rochester, Minn., and his subject, "Cancer of the Gastrointestinal Tract: Its Early Manifestations."

Symposium on Influenza.—The St. Louis Medical Society sponsored a symposium on influenza in St. Louis, February 11. The following members of the faculty of Washington University School of Medicine, St. Louis, spoke:

Dr. Samuel B. Grant, Clinical Features of the Different Epidemics of Influenza.
Louis A. Julianelle, Ph.D., The Etiology of Influenza.
Simon Edward Sulkin, Ph.D., Epidemiology.
Dr. Carl G. Harford, Specific Prophylaxis.

Jacques J. Bronfenbrenner, Dr.P.H., professor of bacteriology and immunology and public health at the school, discussed the presentations.

Society News.—The St. Louis Medical Society was addressed, March 4, by Drs. Daniel L. Sexton on "Role of the Internist in Management of Hyperthyroidism" and Willard Bartlett Jr., "Objectives of Operation in the Treatment of Toxic Goiter."——The Buchanan County Medical Society was addressed in St. Joseph, February 5, by Drs. Robert O. D. Pearman on "Use of Plasma Transfusions in Surgery" and Thomas L. Howden, "Use of Plasma in Medicine." Both are of St. Joseph.——Dr. Paul C. Bucy, Chicago, addressed the Kansas City Academy of Medicine, March 21, on "Experimental Studies on the Functions of the Brain."

NEW JERSEY

Hudson County Course on Tuberculosis.—The advisory committee on tuberculosis and the committee on postgraduate education of the Medical Society of New Jersey have arranged a postgraduate course on pulmonary tuberculosis to be given at the Hudson County Tuberculosis Hospital, Jersey City, Monday and Friday afternoons by members of the staff, April 4-25. The lecturers will be:

Dr. Isadore Earle Gerber, New York, Pathogenesis of Pulmonary Tuberculosis, April 4.
Dr. Gerber, Bacteriology and Immunity in Tuberculosis, April 7.
Dr. Samuel Cohen, Clinical Classification of Pulmonary Tuberculosis, April 11.
Dr. Abraham E. Jaffin, Case Finding: The Role of the Physician and the Clinic, April 14.
Dr. Harry J. Perlberg, Interpretation of Fluoroscopic and X-Ray Findings in Pulmonary Tuberculosis, April 18.
Dr. Benjamin P. Potter, Medical Treatment of Pulmonary Tuberculosis, April 21.
Dr. Frank Bortone, Surgical Treatment of Pulmonary Tuberculosis, April 25.

NEW YORK

Annual Report on Typhoid Carriers.—The state department of health reports that 434 typhoid carriers, exclusive of those in state institutions, were under supervision in upstate New York at the close of 1940. Thirty-seven new carriers were added during the year. Twenty-eight of these were discovered as a result of investigation of sporadic cases of typhoid, 1 by means of release cultures, 1 in the course of an examination of a food handler and 2 accidentally at the time of a cholecystectomy. Five previously discovered carriers were added to the register: 2 had been living outside the state and the remainder in New York City. Twenty-five names were removed from the register. Fifteen died, 6 were released after cholecystectomy, 1 was committed to a state institution and 3 moved to other jurisdictions, according to *Health News.*

Society News.—Dr. Leon H. Cornwall, New York, addressed the Onondaga County Medical Society, Syracuse, March 4, on "Medical Science and Political Philosophy."——Dr. Louis H. Bauer, Hempstead, L. I., addressed the Syracuse Academy of Medicine, March 18, on "Aviation Medicine."——Dr. Philip M. Stimson, New York, addressed the Medical Society of the County of Westchester, White Plains, March 18, on "Acute Contagious Diseases of Childhood."——Dr. Clay Ray Murray, New York, addressed the Medical Society of the County of Albany in Albany, February 26, on "Problem Fractures About the Elbow Joint."——Dr. Edward H. Rynearson, Rochester, Minn., addressed the Rochester Academy of Medicine, March 4, on "Endocrinology: A Critical Appraisal."——Drs. Russell Plato Schwartz and Carl T. Harris, Rochester, gave an illustrated public lecture on "Painful Feet and Aching Back," February 23, under the auspices of the Medical Society of the County of Monroe, the Rochester Academy of Medicine and the University of Rochester School of Medicine and Dentistry.

New York City

The Biggs Lecture.—The annual Hermann M. Biggs Lecture of the New York Academy of Medicine will be delivered, April 3, by Dr. Clarence A. Mills, James T. Heady professor of experimental medicine, University of Cincinnati College of Medicine. His subject will be "Relation of Climate and Geography to Health."

Miller Memorial Lecture.—Dr. Esmond R. Long, director of the Henry Phipps Institute, University of Pennsylvania, Philadelphia, will deliver the Adam M. Miller Memorial Lecture at the Long Island College of Medicine, March 28. Dr. Long's subject will be "Environment and Constitution in the Development of Tuberculosis."

Cuban Committee Visits Cornell.—Six members of the faculty of the University of Habana Faculty of Medicine spent the week of January 20-27 in New York at the invitation of Cornell University Medical College on a travel grant made available by the Department of State. The group compose a permanent committee which has been cooperating for the past two years in an exchange of undergraduate students and teaching personnel with Cornell. The Cuban delegation included Drs. Angel Vieta-Barahona, dean of the faculty of medicine; Alberto Inclan, Carlos E. Finlay, Alfredo Antonetti, Felix A. Hurtado and Edward McGough.

Society News.—Drs. Rosario Mule and Silik H. Polayes, among others, addressed the Brooklyn Urological Society, March 11, on "Medical Aspects of Renal Calculi" and "The Pathology of Symmetrical Cortical Necrosis of the Kidneys" respectively.—— Speakers before the Medical Society of the County of New York, February 24, were Lieut.-Col. Maurice E. Barker, U. S. Army, Washington, D. C., on "Some of the Medical Problems of the Chemical Warfare Service"; Dr. Samuel M. Strong, Flushing, "The Doctor's Relation to Aviation," and Dr. Lowell S. Selling, Detroit, "Mental Hygiene Aspect of the Deferred Draftee."——Drs. Frederick MacCurdy and Harry Projector addressed the Bronx County Medical Society, February 19, on "The Hospital and the Community" and "The Present and Future Status of Private Medical Practice" respectively.—— Dr. Charles F. Geschickter, Baltimore, addressed the Bronx Pathological Society, February 18, on "The Pathology and Etiology of Mammary Cancer."——Drs. John H. Garlock and Armistead C. Crump addressed the New York Society for Thoracic Surgery, February 14, on "The Present Status of Surgical Treatment of Carcinoma of the Thoracic Esophagus" and "Differential Diagnosis of Lesions of the Lower Esophagus" respectively.——Dr. Paul D. White, Boston, addressed the Academy of Pathological Science at a meeting at the New York Medical College, Flower and Fifth Avenue hospitals, January 24, on "Arteriosclerotic Aneurysms of the Aorta."——Dr. Robert D. Mussey, Rochester, Minn., addressed the Medical Society of the County of Queens, February 25, on "Endometriosis."

NORTH CAROLINA

Changes in Health Officers.—Dr. William K. McDowell, Scotland Neck, has been appointed health officer of Richmond County with headquarters at Rockingham.——Dr. Herbert A. Hudgins, Winston-Salem, has been elected health officer of the Rutherford-Polk health district.——Dr. Frank E. Wilson, Tarboro, has resigned as health officer of Edgecombe County to take a course in public health at the University of North Carolina.

Alumni Without an Alma Mater.—Dr. Julius V. Dick, Gibsonville, was elected president of the alumni association of the University of North Carolina School of Medicine at Raleigh, now out of existence, at the annual meeting on February 22 in Chapel Hill. Dr. Joseph N. Moore, Marshall, was elected vice president and Dr. Robert P. Noble, Raleigh, secretary. Drs. Isaac H. Manning, Chapel Hill, and John A. Ferrell, New York, were speakers. The Raleigh unit of the university went out of existence in 1910, and the association of alumni was formed in 1928.

Society News.—Speakers at a meeting of the Mecklenburg County Medical Society, Charlotte, February 4, were Drs. Angus M. McDonald Jr. on "Use of Testosterone in Dysfunction of Male Genital Organs"; Silas Raymond Thompson, "Present Status of Prostatic Surgery," and George Aubrey Hawes, "Present Day Concept in the Study of Male Sterility." All are of Charlotte.——Dr. Irving S. Wright, New York, addressed the Guilford County Medical Society, Greensboro, February 6, on "Diagnosis and Treatment of Obliterative Arterial Disease."——Dr. David T. Smith, Durham, addressed the Forsyth County Medical Society, Winston-Salem, February 18, on "Clinical Applications of Recent Advances in Immunology and Bacteriology."——Dr. Adam T. Thorp, Rocky Mount, discussed eclampsia at a meeting of the Fourth District Medical Society, February 18, in Eureka.

PENNSYLVANIA

Research on Standards of Living.—Pennsylvania State College at State College has established the Ellen H. Richards Institute to study improvements in standards of living in the field of food, clothing and shelter. The unit will take over investigations that have been carried on in the departments of chemistry and home economics and in the agricultural experiment station of the college. Among others, research studies in human nutrition, begun in 1935, will be continued. The institute was named for Ellen H. Richards (1842-1911), for many years instructor in sanitary chemistry at Massachusetts Institute of Technology, who has been called the founder of household science in this country in its modern sense. Pauline Beery Mack, Ph.D., who has been on the staff of the school of chemistry and physics at Pennsylvania State College since 1919 and director of research in home economics since 1935, is the first director of the new institute.

Society News.—Laurance E. Shinn, Ph.D., Pittsburgh, addressed the Washington County Medical Society in Washington, March 12, on "Some Problems Concerning the Action of Sulfamilamide and Related Drugs."——Dr. Mortimer Cohen, Pittsburgh, discussed "Blood Transfusions" at a meeting of the Fayette County Medical Society, Uniontown, March 6.——Lieut.-Col. Frank H. Dixon, U. S. Army, addressed the Dauphin County Medical Society, Harrisburg, March 4, on medical preparedness.——Drs. Joseph C. Yaskin and Robert A. Groff, Philadelphia, addressed the Harrisburg Academy of Medicine, March 18, on "Diagnosis and Management of Operable Brain Lesions."——Dr. James M. Surver, Philadelphia, addressed the Blair County Medical Society, Altoona, February 25, on carcinoma of the stomach.

Philadelphia

Meeting on Diabetes.—Drs. Howard F. Root, Boston, and J. West Mitchell, Pittsburgh, were guest speakers before the Philadelphia County Medical Society, March 12, on "The Possibilities of Cure of Diabetes" and "The Diabetic Group of Diseases" respectively. Dr. Joseph T. Beardwood Jr. discussed "Borderline Metabolic States in Military Personnel" and Dr. Edward Roland Snader, chairman of the society's diabetic committee, the aims and accomplishments of that committee.

Annual Postgraduate Institute.—Evening features of the Sixth Annual Postgraduate Institute of the Philadelphia County Medical Society, March 31 to April 4, will include round table discussions. The first will be held Monday evening, March 31, with Dr. Harrison F. Flippin leading the discussion on "Chemotherapy" with the following assistants: Drs. Dale C. Stahle, Harrisburg; John A. Kolmer, Edward H. Campbell, Harry Lowenburg, Walter W. Baker, Isidor S. Ravdin and Leon Schwartz. Tuesday evening the subject will be "Surgical Aspects of Peptic Ulcer" with Dr. George P. Müller as the leader and Drs. Eldridge L. Eliason and Thomas A. Shallow as assistants. The annual dinner and dance will be given Wednesday evening at the Bellevue-Stratford Hotel. There will also be a luncheon the first day, at which the speakers will include Mayor Lamberton, Drs. Hubley R. Owen, city director of health, John J. Shaw, state secretary of health, Harrisburg, and Lewis T. Buckman, Wilkes-Barre, president-elect of the Medical Society of the State of Pennsylvania.

Pittsburgh

Doctors' Orchestra Organized.—Physicians and dentists of Pittsburgh have organized a symphony orchestra and began rehearsals February 6, with more than forty present. Dr. Myer W. Rubenstein is president of the new organization and Gaylord Yost is the conductor.

Three Health Supplements.—Three Pittsburgh newspapers have recently published health supplements under the sponsorship and direction of the bureau of medical information of the Allegheny County Medical Society. The Pittsburgh *Press* in its supplement, February 25, took as its theme "Medicine and National Defense"; the *Sun-Telegraph*, February 27, "Healthy Americans," and the *Post-Gazette*, March 7, "Health in the Pittsburgh District." The material was written by members of the society and edited by the bureau of medical information, and the advertisements were approved by the bureau.

SOUTH CAROLINA

Personal.—Dr. Karl L. Able was elected mayor of Leesville recently.——Dr. Olin Sawyer, Georgetown, was recently appointed medical director of the South Carolina Industrial Commission, according to a newspaper report.——An oil portrait of Dr. Charles A. Mobley, Orangeburg, was presented to the Tri-County Hospital, Orangeburg, January 5, by the medical staff of the hospital. Dr. Mobley, who has served as president of the South Carolina Medical Association, was honored for his work in promoting hospital facilities in the area. Through the establishment of the Orangeburg Hospital twenty-one years ago he laid the foundation for the present Tri-County Hospital, it was said. Dr. Lawrence P. Thackston, chief of staff, made the presentation.

Postgraduate Assembly for Negro Physicians.—The first postgraduate assembly for Negro physicians in South Carolina was held at State College, Orangeburg, January 28-30, under the auspices of the U. S. Public Health Service, National Tuberculosis Association, South Carolina Tuberculosis Association, South Carolina Sanitarium, the South Carolina State Board of Health, the Palmetto Medical Association and State College. Lectures were presented on obstetrics, pediatrics, tuberculosis and venereal disease by Drs. Robert E. Seibels, William Weston Jr., Robert W. Ball and Sedgwick Simons, Columbia; Pedro Martir Santos, Chicago; Nolan A. Owens, Washington, D. C.; William B. Perry, special consultant, U. S. Public Health Service; Orville L. Ballard, Waverly Hills, Ky., and John M. Preston, South Carolina Sanatorium, State Park.

TENNESSEE

Society News.—A symposium on pneumonia was presented at a meeting of the Memphis and Shelby County Medical Society, January 21, by Drs. Frank T. Mitchell, Alfred M. Goltman, Lucius C. Sanders and Conley H. Sanford. All are from Memphis.——Dr. Charles L. Scudder, Boston, addressed the Chattanooga and Hamilton County Medical Society, January 23, on "Transportation and Treatment of Fractures."——Dr. Herbert Acuff, Knoxville, addressed the Washington, Carter and Unicoi Counties Medical Society in Johnson City, February 6, on "Thoracic Surgery" and Dr. Edward T. Brading, Johnson City, on the pneumonia control program in Tennessee.

Lectures on Poliomyelitis at Vanderbilt.—Six lectures on poliomyelitis will be presented at Vanderbilt University, Nashville, in April under the sponsorship of the National Foundation for Infantile Paralysis. The series is as follows:

Paul F. Clark, Ph.D., Madison, Wis., The History of Poliomyelitis, April 7.
Dr. Charles Armstrong, U. S. Public Health Service, Washington, D. C., The Etiology of Poliomyelitis, April 8.
Dr. Thomas M. Rivers, New York, Immunity to Poliomyelitis, April 9.
Dr. Ernest W. Goodpasture, Nashville, Pathology and Pathogenesis of Poliomyelitis, April 14.
Dr. John R. Paul, New Haven, Conn., Epidemiology of Poliomyelitis, April 15.
Dr. Frank R. Ober, Boston, Treatment and Rehabilitation of Poliomyelitis Patients, April 16.

TEXAS

Radiology Meeting.—The annual meeting of the Texas Radiological Society was held in Sherman, January 18. The speakers included:

Dr. Fred J. Hodges, Ann Arbor, Mich., The Utility of Radiological Methods in Gastrointestinal Diagnosis.
Dr. Wendell M. Long, Oklahoma City, Diagnostic Problems Encountered in Carcinoma of the Cervix.
Dr. Leon J. Menville, New Orleans, Irradiation in Endocrine Dysfunction, Particularly Hyperthyroidism.
Dr. James R. Maxfield Jr., Albuquerque, N. M., Evaluation of Radiation Methods Now Available for the Treatment of Cancer.
Dr. Roscoe P. O'Banion, Fort Worth, Fracture of the Dorsal Spine Following Metrazol Therapy.
Dr. Paul C. Williams, Dallas, Scoliosis.
Dr. Jesse B. Johnson, Galveston, X-Ray Manifestations in Nutritional Deficiencies of Bone.

Dr. Glenn D. Carlson, Dallas, was named president-elect and Dr. Milton H. Glover, Wichita Falls, became president.

UTAH

Annual Registration Due April 1.—All practitioners of medicine and surgery licensed to practice in Utah are required to register annually on or before April 1 with the Department of Registration and to pay a fee of $3. If a licentiate fails to reregister within ninety days to six months after April 1, his license can be revoked and, if revoked, it will be reinstated thereafter only on his paying the delinquent registration fee and an additional year's fee as a penalty.

WASHINGTON

Society News.—Drs. Raymond A. Lower and Donald A. Palmer, Spokane, addressed the Spokane County Medical Society, February 13, on "Nonopaque Foreign Bodies of the Lung" and "An Unusual Case of Cardiospasm" respectively.——Drs. William Y. Baker and Edward D. Hoedemaker addressed the King County Medical Society, Seattle, March 3, on "Present Status of Active Therapies of the Psychoses" and "Present Status of the Treatment of Neuroses" respectively. Drs. Brien T. King, Charles B. Ward and Sylvester N. Berens addressed the society, Seattle, February 17, on "Postoperative Exophthalmos," and Dr. Harry J. Friedman, "Vascular Diseases of the Extremities."

WYOMING

Personal.—Drs. Charles W. Jeffrey, Rawlins, and George W. Earle, Casper, are serving in the state house of representatives.

Annual Registration Due April 1.—All practitioners of medicine and surgery licensed to practice in Wyoming are required by law to register on or before April 1 with the secretary of the Board of Medical Examiners and to pay a fee of $2.50. If a licentiate fails to pay the fee within three months after April 1 his license can be annulled, and, if annulled, it will be reinstated only on his paying the stated fee plus $5 as a penalty.

GENERAL

Registry for Technologists Moved to Indiana.—The Registry of Medical Technologists of the American Society of Clinical Pathologists has been moved from Denver to the Ball Memorial Hospital, Muncie, Ind. The registry has been located in Denver since its organization in 1928 and has been administered by Dr. Philip Hillkowitz as chairman of the board and Mrs. Ann R. Scott, the registrar. With the recent resignation of Dr. Hillkowitz and Mrs. Scott, Dr. Lall G. Montgomery, Muncie, was chosen chairman, and Miss Carlita R. Swenson, formerly with the U. S. Pharmacopeia, Philadelphia, registrar.

Hospital Superintendent Wanted.—There will be a position open for superintendent of a municipally controlled hospital of two hundred and fifty beds, one half of which is for treatment of contagious diseases and the other half for treatment of tuberculosis. Applicants for this position must have had previous administrative experience in responsible hospital positions, including buying of hospital supplies. The contemplated salary is $7,500 without maintenance. Applications should be filed as soon as possible. Additional information may be obtained from the Chairman of the Board of Trustees, Belmont Hospital, Worcester, Mass.

Study of Neoplastic Diseases.—The spring meeting of the American Association for the Study of Neoplastic Diseases will be held at Garfield Hospital, Washington, D. C., April 3-5. The meeting will be a demonstration of microscopic pathology, roentgenograms and lantern slides on the following topics: lesions of the female genital system; lesions of bones; endothelioma of meninges, nerve trunks and ganglions, serous membranes, bone, skin, ovary, lymph nodes; lesions of the gastrointestinal tract; lesions of the endocrine glands; lesions of the male genitourinary system. One session will be devoted to a visit to the National Institute of Health, Bethesda, Md., and to a discussion of treatment in neoplasia. The president of the association is Dr. Roscoe W. Teahan, Philadelphia, and the secretary is Dr. Eugene R. Whitmore, Washington, D. C.

Meeting of Dermatologists.—The sixty-fourth annual meeting of the American Dermatological Association, Inc., will be held at the Hotel Roosevelt, New Orleans, April 7-10, under the presidency of Dr. William H. Guy, Pittsburgh. Among the speakers will be:

Drs. William Howard Hailey and Hugh E. Hailey, Atlanta, Poikiloderma Congenitale.
Drs. Vicente Pardo-Castello, E. Rio Leon and F. Trespalacios, Havana, Chromoblastomycosis in Cuba.
Drs. Clark W. Finnerud and Roland L. Kesler, Chicago, Ingestion of Lard in the Treatment of Eczema and Allied Dermatoses.
Drs. Frank J. Eichenlaub, Robert Stolar and Alvin E. W. Wede, Washington, D. C., Prevention of Transfusion Syphilis.
Dr. Clarence Guy Lane and Irving H. Blank, Ph.D., Boston, Sulfonated Oil as a Detergent in a Dermatologic Ward.

The program will be concluded with a symposium on superficial fungous infections. An automobile trip will then be conducted to the National Leprosarium at Carville, where a clinic on leprosy will be held.

The Foundation Prize.—The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces that its "Foundation Prize" of $150 is again offered. Eligible contestants include (*a*) interns, residents or graduate students in obstetrics, gynecology or abdominal surgery and (*b*) physicians who are actively practicing or teaching in these fields. Manuscripts must be presented under a nom de plume to the secretary of the association together with a sealed envelop bearing the nom de plume and containing a card showing the name and address of the contestant. Manuscripts must be limited to 5,000 words and must be typewritten in double spacing on one side of the sheet, with ample margins. Illustrations should be limited to such as are required for clear

exposition of the thesis. Three copies of all manuscripts must be in the hands of the secretary before June 1. The award will be made at the annual meeting of the association, at which time the successful contestant must appear in person to present his contribution as a part of the program. The contestant must meet all expenses incident to this presentation. The successful thesis becomes the property of the association, but this provision shall in no way interfere with publication of the communication in the journal of the author's choice, according to the rules. The secretary is Dr. James R. Bloss, 418 Eleventh Street, Huntington, W. Va.

Birth Rate Highest in Decade.—About 2,350,000 babies were born in the United States in 1940, the highest number since 1930, according to a report by the bureau of the census February 17. The total was nearly 100,000 greater than in 1939 and the increase lifted the national birth rate from 17.3 to 18 live births per thousand of population. From a rate of 24.2 in 1921 the rate continuously declined to its lowest point, 16.5, in 1933. Since then it has risen irregularly. The census bureau points out that the long range tendency is still downward, the present rise resulting from the fact that babies born from the greatly increased volume of marriages following the first World War are now coming into reproductive ages. The provisional death rate for 1940 also registered a slight increase, 10.8 per thousand of population, and the infant mortality rate decreased slightly, 47.9 deaths per thousand live births. Census statisticians point out that, despite the birth increase in 1940, barely enough children are being born to replace the present generation. An unusually large number of women are now in the child bearing ages. As they grow older, birth rates will continue to drop and death rates rise, offsetting the present gradual growth in population. The census bureau recently announced that, if the average birth and death rates prevailing from 1935 to 1939 continue, the reproduction rate of white persons forecasts an eventual decrease of 4 per cent with each generation. The reproduction rate is computed by a comparison of the number of female babies born in a generation from a given number of women of reproductive age.

CANADA

Professor of Radiology Appointed.—Dr. William W. Bryan, Montreal, has been appointed professor of radiology at the University of Western Ontario Faculty of Medicine, London, Ont., and radiologist at the Victoria Hospital.

Society News.—Dr. Harry C. Solomon, Boston, addressed the Academy of Medicine of Toronto, February 4, on "The Treatment of Neurosyphilis." Dr. Walter T. Dannreuther, New York, will be the speaker, April 1, on "The Treatment of Endometriosis."

New Dean at Laval University.—Dr. Charles Vezina, professor of clinical surgery, Laval University Faculty of Medicine, Quebec, has been appointed dean of the medical school to succeed the late Dr. P. Calixte Dagneau. Dr. Vezina graduated from Laval in 1913.

Overseas Medical Society Formed.—Medical officers of the First Canadian Division, now in England, have formed a medical society, which has been granted affiliation with the Canadian Medical Association. Col. Emmet A. McCusker, Regina, Sask., was elected president and Major Gordon A. Sinclair, Grimsby, Ont., secretary. Major Israel M. Rabinowitch, Montreal, gave an address on war gases and first aid measures for each gas at a recent meeting.

LATIN AMERICA

New Health Officials in Mexico.—With the inauguration of President Manuel Avila Camacho the appointment of new health officials has been announced in Mexico. Dr. Victor Fernández Manero is the new head of the department of health, and Dr. Mario Quiñones is secretary. Dr. Gustavo Baz is secretary of public welfare.

Course at Cordoba University.—A course on surgery of biliary lithiasis will be presented at the National University of Cordoba, Argentina, May 15-31, under the direction of Dr. Pablo L. Mirizzi. The course will include lectures, practical classes, operative sessions, clinical exercises, interpretation of roentgenograms and demonstration of operative technic, presented by Dr. Mirizzi and his staff. Information may be obtained from Dr. Mirizzi, Hospital Nacional de Clinicas, Calle Santa Rosa 1562, Cordoba, Argentina.

Government Services

Report of Bureau of Narcotics

The number of persons arrested for violations of the federal narcotic laws (excluding marihuana) during the calendar year 1940 was 2,216, as compared with 3,295 in 1939, according to a report of the enforcement agencies of the Treasury Department. The number of marihuana arrests was nearly the same, 870 in 1940 and 864 in 1939.

Figures presented by the Bureau of Narcotics show a decrease also in the amount of drugs seized. In the internal traffic, the bureau seized approximately 2,292 ounces in 1940, as compared with 3,544 ounces in 1939. The Bureau of Customs seized at ports and borders approximately 2,286 ounces in 1940 as compared with 8,895 in 1939.

Activity in the control of marihuana was increased. In the illicit traffic 20,960 ounces of bulk marihuana was seized, including 3,450 ounces seized at ports and borders, as compared with 17,035 in the previous year. In addition, the authorities seized 19,560 cigarets, including 1,243 seized at ports and borders, slightly more than in 1939, when the total was 19,091. Marihuana growing on approximately 19,000 acres of land was destroyed as compared with 6,506 acres in 1939.

In a statement before the subcommittee of the Committee on Appropriations of the House of Representatives, January 8, Mr. H. J. Anslinger, commissioner of narcotics, said there is a great reduction in drug addiction throughout the country, because the drugs are so highly diluted that they do not maintain the habit. However there has been an increase in the number of robberies of drug stores, wholesale houses and physicians, and the addict is resorting to forged prescriptions as well as to paregoric and other exempt preparations.

Interdepartmental Committee on Health and Welfare

Federal Security Administrator Paul V. McNutt has appointed an Interdepartmental Advisory Committee to advise him in coordinating all health, medical care, welfare, nutrition, recreation and related activities affecting national defense. In addition Mr. McNutt has established twelve regional advisory councils made up of the field representatives of all federal agencies participating in these activities, with the regional directors of the Social Security Board as regional defense coordinators. These coordinators will act as chairmen of the regional advisory councils and maintain the relationships in these fields with the state defense councils in their respective regions. Members of the new committee include:

Arthur J. Altmeyer, chairman of the Social Security Board.
Aubrey Williams, administrator of the National Youth Administration.
John W. Studebaker, LL.D., director, Office of Education.
Dr. Warren F. Draper, U. S. Public Health Service.
Calvin B. Baldwin, administrator, Farm Security Administration.
Milburn L. Wilson, director of extension work.
Milo R. Perkins, administrator, Surplus Marketing Administration.
Louise Stanley, Ph.D., chief, Bureau of Home Economics.
John M. Carmody, administrator, Federal Works Agency.
Howard O. Hunter, acting commissioner, Work Projects Administration.
Frances Perkins, Secretary of Labor.
Katherine Lenroot, chief of the Children's Bureau.
Conrad Wirth of the National Park Service.
Harold W. Breining, assistant administrator, Veterans Administration.
Charles W. Eliot II, director, National Resources Planning Board.

Five additional members of this committee are members of the Advisory Commission to the Council of National Defense: Frank Bane, director of the division of state and local cooperation; Charles Palmer, housing coordinator; John B. Hutson, Ph.D., agriculture division; Sidney Hillman, labor division, and Harriet Elliott, consumer protection division.

Division of Industrial Hygiene Reorganized

The division of industrial hygiene in the National Institute of Health, Bethesda, Md., has been reorganized with Dr. James G. Townsend, medical director, U. S. Public Health Service, as chief. Two new administrative sections have been created to facilitate the division's relationship to national defense: the states relations section and defense activities with John J. Bloomfield, sanitary engineer, as chief, and the research section in charge of Dr. Paul A. Neal. In this reorganization Passed Asst. Surg. Waldemar C. J. Dreessen directs the medical personnel; Passed Asst. Sanitary Engineer (R.) A. D. Brandt is in charge of the engineering unit, and the statistical work of the division falls to Senior Statistician William M. Gafafer. Dr. Townsend was transferred from the Office of Indian Affairs, Washington, to the new work.

Foreign Letters

PARIS

(From Our Regular Correspondent)

Aug. 24, 1940.

Medical Life in France

Medical life in France is undergoing great changes. The unforeseen and rapid occupation of the capital by the army of invasion threw not only the hospital and health services but also academic life and scientific output into confusion. Many periodicals have discontinued publication. Others had to reduce the number of their pages by half. Beginning with the first of the year, articles signed by Jews may not be published. The cutting off of communication between free and occupied France has practically made two countries of France. The number of physicians in the capital has fallen tremendously. Of the six thousand five hundred physicians in Paris and the department of the Seine, only two thousand remained after the mobilization at the end of April. This number was further reduced to four hundred and fifty by June 14, the day the nazis entered Paris. While large numbers of the population fled, the reduction was not so great as to make the greatly reduced body of physicians sufficient for the needs of the people. Whole areas of the city could show neither medical practitioner, midwife nor druggist. Sanitary offices had likewise ceased. The faculty of medicine, the laboratories and the libraries were almost abandoned. Public health was seriously menaced. Thanks to the courageous initiative of voluntary health committees, such as that of Paris and its environments, no epidemics occurred. The Academy of Medicine, which had planned a refuge in advance, remained at its post, though in greatly reduced number and with curtailment of its activities. However, its meetings were regularly held. The Pasteur Institute continued its work without interruption. Gradually, general practitioners returned, the hospitals were reopened and health services were resumed.

The French medical press was inundated by publicity. No discrimination was made between legitimate specialties and commercial exploitation. To correct these conditions, the government has appointed as health director not a politician, as was formerly done, but Dr. Serge Huart, a physician. Among the reforms introduced by him is one that may serve as an index of present social tendencies, namely the regulation which prohibits the practice of medicine to those whose fathers were not Frenchmen, unless they themselves have seen service in the French army or made some scientific contribution to the country of their adoption. This law strikes especially at the Jews. In the department of the Seine, nine hundred Jewish physicians will have to terminate their practice at once. Whatever hardships may be involved in this reform, it should be remembered that considerable abuses had crept in under the liberalism of French laws. Alien physicians from all points of the compass, many of whom could scarcely speak French, had abused the privileges shown them by the country by first obtaining a medical university diploma, which does not confer the right to practice, and then converting it with the aid of politicians into a state diploma. Not only that, but these aspirants to medical practice did not settle in rural districts, where often there was only one physician for three thousand inhabitants, but in cities already well supplied and especially in Paris, where they were so numerous that the ratio was that of one physician for six hundred inhabitants.

The health service has been reorganized, and reorganization was greatly needed. Heretofore fifty-two bureaus spread among seventeen ministries exercised powers that were archaic, involved and inefficient. For example, milk control was in charge of the veterinary department of the ministry of agriculture, but it had no powers against violators of the milk laws. The officers of the ministry of health charged with the execution of health laws were the prefects and as such functioned under the ministry of the interior. They were assisted in part by local agents and thereby subjected to influences detrimental to efficiency. No unitary conception of public health services existed. The new order seems to promise a greater efficiency. An intimate association has been established between the family and health. No one will deny that these are vital problems with the strongest interrelations. The future of the race, its fertility, its ethnic significance are bound up with the problems of alcoholism, syphilis, nutrition, physical education, infant welfare and others. In the new setup the influence of local functionaries is minimized. They are replaced by administrative and supervisory officers, divided into twenty health districts, which are to replace the eighty-nine departments. These sanitary staffs will have a wider territory to cover, will be more independent and technically more centralized, and possess a correspondingly greater authority.

Another reform affects the medical profession directly. The medical syndicates and their confederation have been abolished. In their place the Order of Physicians has been created. This is not a new idea in France and has always aroused a lively opposition on the part of the medical profession, because the government has insisted that it be composed of physicians and magistrates, with the latter in the majority. The medical syndicates, organized on the basis of family councils, made some contribution to ethical standards but had no power except over the syndicates themselves. In future all physicians are subject to jurisdiction of the order, before which they will take their oath. It has the power of suspension or refusing the right to practice. A superior council of the order composed of fifteen members with Professor Leriche as its president has been designated. It, in turn, will appoint a departmental and regional council for each department and region. The order is charged with maintaining the honor and the ethical standards of the profession and with representing its members before the public authorities.

Marriages

JOHN THORNTON MITCHELL to Miss Marie Hazelhurst Hammond, both of La Grange, Fla., in Fort Lauderdale recently.

WILFRED EARL ALLYN JR., Shaker Heights, Ohio, to Miss Dorothy Ruth Newton at Cleveland Heights recently.

WILLIAM MONCURE DABNEY to Miss Lavinia Scott, both of Okolona, Miss., in Aberdeen, Oct. 18, 1940.

SIDNEY MARVIN COPLAND, New Orleans, to Miss Muriel Ruth Freilich of Chicago, January 11.

HAROLD MICHAEL FLORY, New Iberia, La., to Miss Opal Holloway Clark of Crowley recently.

JOHN D. CONNER, Nevada, Iowa, to Miss Agnes Marie Weyers of Des Moines, Dec. 25, 1940.

LAUREN MCCALL SOMPAYRAC to Miss Lois Sypert Cleveland, both of Jacksonville, Fla., recently.

WALTER HUNTER WATSON to Miss Mary Norvell Johnson, both of Charleston, S. C., recently.

ADOLPH SOUCEK to Miss Mary Considine, both of Cherokee, Iowa, in Marcus, Dec. 28, 1940.

WILLIAM A. LANGE, Detroit, to Mrs. Annie Laurine Dodge in Champaign, Ill., January 30.

JOSEPH M. FRIEDMAN to Miss Irma Silman, both of Washington, D. C., Dec. 21, 1940.

JAMES A. FERRY to Miss Mildred Cosby Hodges, both of Birmingham, Ala., recently.

PRICE SEWELL JR., Ashland, Ky., to Miss Juliet Rumph at Lagrange, Dec. 27, 1940.

LEONARD S. ANNIS to Miss Lou Washington, both of Tampa, Fla., in December 1940.

HUGH F. MCMANUS JR., Raleigh, N. C., to Miss Kay Cash of Durham, January 18.

Deaths

Claude Adelbert Burrett ✱ New York; Cleveland Homeopathic Medical College, 1905; director of the pathogenic laboratory and instructor in toxicology, University of Michigan College of Homeopathic Medicine, Ann Arbor, from 1905 to 1908, assistant professor of genitourinary surgery, dermatology and electrotherapeutics from 1908 to 1913 and professor of surgery and genitourinary surgery, 1913-1914; professor of surgery and acting dean, 1914-1915; dean and professor of surgery, Ohio State University College of Homeopathic Medicine, Columbus, from 1915 to 1922; since 1939 president and from 1925 to 1939 dean, professor of surgery and director at the New York Medical College, Flower and Fifth Avenue Hospitals, formerly known as the New York Homeopathic Medical College and Flower Hospital; fellow and formerly member of the board of governors of the American College of Surgeons; was on the medical council of the state board of regents; during the World War was surgeon to the student army training corps at Ohio State University and a member of the medical division of the Ohio War Defense Board; a trustee of Syracuse University; aged 62; died, March 3, of cerebral hemorrhage.

Joseph Augustus White ✱ Richmond, Va.; University of Maryland School of Medicine, Baltimore, 1869; an Affiliate Fellow of the American Medical Association and chairman of its Section on Ophthalmology, 1884-1885; one of the founders of the University College of Medicine, Richmond; for many years professor of ophthalmology, otology, rhinology and laryngology and later emeritus professor of otolaryngology and ophthalmology at the Medical College of Virginia; at one time professor of eye and ear diseases at the Washington University Medical Department, Baltimore; past president of the Richmond Academy of Medicine, the Tri-State Medical Association of the Carolinas and Virginia, the Medical Society of Virginia, the American Laryngological, Rhinological and Otological Society; member of the American Ophthalmological Society and the American Otological Society; aged 92; died, February 16, of myocarditis.

John Preston Sutherland, Boston; Boston University School of Medicine, 1879; member of the Massachusetts Medical Society; served at his alma mater as assistant in clinical medicine from 1881 to 1882, assistant in pathology and therapeutics from 1883 to 1884, lecturer on anatomy in 1887, professor of anatomy from 1888 to 1907, professor of theory and practice from 1908 to 1937, professor of medicine since 1937, registrar from 1896 to 1899, acting dean from June 1897 to 1900, dean from 1900 to 1923 and dean emeritus since 1923; served in various capacities on the staff of the Massachusetts Homeopathic Hospital; consulting physician and trustee of the Massachusetts Memorial Hospital; author of "Malnutrition, The Medical Octopus"; aged 87; died, February 22, of coronary thrombosis.

Edward Jewett Goodwin ✱ St. Louis; Washington University School of Medicine, St. Louis, 1894; an Affiliate Fellow of the American Medical Association and member of its House of Delegates from 1909 to 1918 and from 1925 to 1934; in 1902 was appointed associate recording secretary and official reporter of the Missouri State Medical Association, in 1903 assistant secretary, in 1910 secretary and in 1938 secretary emeritus; associate editor of the *Interstate Medical Journal* from 1903 to 1910; in 1905 became associate editor of the *Journal of the Missouri State Medical Association*, in 1906 editor and in 1938 editor emeritus; aged 76; died, February 18, of heart disease.

Sherman Fletcher Gilpin ✱ Philadelphia; Jefferson Medical College of Philadelphia, 1896; member of the American Neurological Association and the American Psychiatric Association; associate professor of nervous and mental diseases at his alma mater from 1908 to 1932 and clinical professor of nervous and mental diseases at Temple University School of Medicine from 1906 to 1908; formerly consulting neuropsychiatrist, State Hospital, and neuropsychiatrist, Moses Taylor Hospital, Scranton; aged 70; served on the staff of the Philadelphia General Hospital, where he died, February 19, of carcinoma of the urinary bladder and uremia.

Thomas William Mason Long ✱ Roanoke Rapids, N. C.; University College of Medicine, Richmond, 1908; secretary-treasurer of the Medical Society of the State of North Carolina; past president of the Halifax County Medical Society and of the fourth district society; at one time member of the state board of medical examiners; formerly mayor; served in the state house of representatives in 1931 and in the senate in 1933, 1937, 1939 and 1941; aged 55; died, February 3, in the Rex Hospital, Raleigh, of coronary occlusion.

Charles T. Chamberlain ✱ Portland, Ore.; Cooper Medical College, San Francisco, 1903; member of the American Laryngological, Rhinological and Otological Society and the Pacific Oto-Ophthalmological Society; clinical professor of otology, rhinology and laryngology at the University of Oregon Medical School; past president of the Portland Otolaryngological Society; on the staff of the Emanuel Hospital and the Doernbecher Memorial Hospital for Children; aged 60; died, Dec. 25, 1940, of cerebral hemorrhage.

Fred Short Ryan ✱ San Jose, Calif.; Northwestern University Medical School, Chicago, 1908; past president of the Santa Clara County Medical Society; fellow of the American College of Surgeons; served during the World War; on the staffs of the San Jose Hospital and O'Connor Sanitarium; superintendent of the Santa Clara County Hospital; aged 58; died, Dec. 1, 1940, of coronary occlusion.

William Miller ✱ Chicago; Northwestern University Medical School, Chicago, 1911; in 1914 clinical assistant in medicine, in 1918 instructor in surgery and from 1921 to 1929 associate in surgery at his alma mater; fellow of the American College of Surgeons; served during the World War; aged 56; on the staff of the Wesley Memorial Hospital, where he died, February 22, of coronary thrombosis.

James Michael O'Neill ✱ Harrison, N. Y.; McGill University Faculty of Medicine, Montreal, Que., Canada, 1903; member of the American Psychiatric Association; served during the World War; formerly member of the school board; for many years resident physician at St. Vincent's Retreat; aged 61; died, January 5, in the United Hospital, Port Chester, of coronary thrombosis.

Walter Concemore Cramp ✱ New York; Columbia University College of Physicians and Surgeons, New York, 1904; formerly clinical professor of surgery at the University and Bellevue Hospital Medical College; fellow of the American College of Surgeons; trustee of Colgate University; aged 62; died, February 18, in the Doctors Hospital of carcinoma of the rectum.

Osmon Huntley Hubbard, Keene, N. H.; McGill University Faculty of Medicine, Montreal, Que., Canada, 1888; member and past president of the New Hampshire Medical Society; past president of the Cheshire County Medical Society; for many years pathologist on the staff of the Elliott Community Hospital; aged 78; died, January 5, of coronary heart disease.

Charles David Dixon, San Antonio, Texas; Jefferson Medical College of Philadelphia, 1895; member of the State Medical Association of Texas; past president of the Bexar County Medical Society; served during the World War; past president of the city board of health; aged 69; died, January 11, in the Station Hospital of pyelitis and arteriosclerosis.

Frank Colgate Benson Jr., Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1894; professor and head of the department of radium therapy at his alma mater; fellow of the American College of Surgeons; aged 69; author of books of poems; on the staff of the Hahnemann Hospital, where he died, February 18, of multiple myeloma.

Fleming Howell, Buckhannon, W. Va.; Long Island College Hospital, Brooklyn, 1879; member and past president of the West Virginia State Medical Association and the Harrison County Medical Society; author of "Our Aryan Ancestors"; aged 91; died, January 9, in St. Joseph's Hospital of arteriosclerosis.

Charles Bismarck Kobert, Danville, Ky.; Medical College of Ohio, Cincinnati, 1901; member of the Kentucky State Medical Association; served during the World War; for many years director of the bureau of trachoma, Kentucky State Board of Health; aged 62; died, Dec. 12, 1940, of nephritis.

Benjamin Price Riley, New York; University of Virginia Department of Medicine, Charlottesville, 1902; clinical instructor in surgery, department of orthopedic surgery, Cornell University Medical College, New York, 1913-1914; aged 70; died, Dec. 21, 1940, of arteriosclerosis and coronary thrombosis.

Joseph F. Pinkham, Belding, Mich.; Victoria University Medical Department, Coburg, Ont., Canada, 1892; member of the Michigan State Medical Society; for many years on the staff of the Blodgett Memorial Hospital, Grand Rapids; aged 74; died, January 9, of cerebral thrombosis.

Henry Branson Henson, White Plains, N. Y.; University of the City of New York Medical Department, New York, 1891; member of the Medical Society of the State of New York; for many years on the staff of the Knickerbocker Hospital, New York; aged 71; died, Dec. 28, 1940.

Andrew James McIntyre, Washington, D. C.; Georgetown University School of Medicine, Washington, 1902; assistant demonstrator in anatomy at his alma mater from 1904 to 1906; formerly associated with the Veterans Administration; aged 63; died, January 11, of coronary thrombosis.

Frank T. Dowd, Indianapolis; Medical College of Indiana, Indianapolis, 1902; member of the Indiana State Medical Association; formerly deputy county coroner, police and fire surgeon; aged 59; died, January 21, of myocarditis, diabetes mellitus and gastrocholecystostomy.

Russell Arthur Salton ● Williamson, W. Va.; Baltimore Medical College, 1911; fellow of the American College of Surgeons; served during the World War; aged 53; on the staff of the Williamson Memorial Hospital, where he died, January 20, of pulmonary embolism.

Robert Wilson Morris, Chicago; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1902; aged 64; on the staff of the Illinois Central Hospital, where he died, January 13, of hypertensive heart disease.

Richard Delaney, Winthrop, Mass.; Harvard Medical School, Boston, 1885; aged 81; died, Dec. 1, 1940, in the Peter Bent Brigham Hospital, Boston, of injuries received when struck by an automobile as he was crossing the street.

Joseph Henry Hutchings ● Woburn, Mass.; University of the City of New York Medical Department, 1887; on the courtesy staff of the Charles Choate Memorial Hospital; aged 77; died, January 12, of chronic myocarditis.

Carlos Emmor Godfrey, Trenton, N. J.; Medico-Chirurgical College of Philadelphia, 1890; director of public records of the state of New Jersey; aged 77; died, January 8, in St. Francis Hospital of cerebral hemorrhage.

Washington A. Harper, Austin, Texas; University of the South Medical Department, Sewanee, Tenn., 1895; University of Nashville (Tenn.) Medical Department, 1896; aged 71; died, January 3, of coronary occlusion.

Edward James Devine ● Chicago; Chicago College of Medicine and Surgery, 1909; served during the World War; on the staff of the Evangelical Hospital; aged 61; died, January 16, of coronary occlusion.

Fred Lamerton Horton ● Pomona, Calif.; University of Nebraska College of Medicine, Omaha, 1916; on the staff of the Pomona Valley Community Hospital; aged 46; died, Dec. 24, 1940, of gastric hemorrhage.

George H. Hunt, Paris, Ill.; Pulte Medical College, Cincinnati, 1882; member of the Illinois State Medical Society; on the staff of the Paris Hospital; aged 81; died, January 8, of hemiplegia and uremia.

David Zelenko, Brooklyn; Columbia University College of Physicians and Surgeons, New York, 1904; aged 59; died, Dec. 2, 1940, in the Beth Moses Hospital of perirectal abscess and paralytic ileus.

Oliver Harrison Griffith ● Wheeling, W. Va.; Medical Department of the University of Cincinnati, 1910; served during the World War; aged 54; died, January 15, of hydrocyanic acid poisoning.

John J. Robrecht, Philadelphia; University of Pennsylvania Department of Medicine, Philadelphia, 1894; member of the Medical Society of the State of Pennsylvania; aged 73; died, Dec. 21, 1940.

Frederick Nussel, Brazil, Ind.; Medical College of Indiana, Indianapolis, 1891; member of the Indiana State Medical Association; health officer; aged 83; died, January 13, of pernicious anemia.

Irving Platt Withington, East Stroudsburg, Pa.; New York Homeopathic Medical College and Hospital, New York, 1906; aged 82; died, Dec. 29, 1940, of cardiovascular renal disease.

Bruno Wolff, Tonawanda, N. Y.; Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, Germany, 1921; aged 49, died, Dec. 26, 1940, of carcinoma of the stomach.

John Jay McClung, Jackson, Ohio; Ohio Medical University, Columbus, 1898; member of the Ohio State Medical Association; aged 68; died, January 3, of heart disease.

Jesse Wilhelm Stenger, Pasadena, Calif.; University of California Medical Department, San Francisco, 1910; aged 59; died, Dec. 26, 1940, of coronary thrombosis.

Edward N. Foster, Center, Texas (licensed in Texas under the Act of 1907); aged 66; died, January 11, of tuberculosis, hypertension and heart disease.

Delon L. Murray, Dexter, Ga.; University of Georgia Medical Department, Augusta, 1911; aged 59; died, Dec. 13, 1940, in a hospital at Dublin.

George John Mehler, Jackson Heights, N. Y.; Columbia University College of Physicians and Surgeons, New York, 1904; died, Dec. 26, 1940.

Andrew Everett Porter, Edmonton, Alta., Canada; University of Pennsylvania Department of Medicine, Philadelphia, 1876; died, Dec. 7, 1940.

Henry Stanislaus Sauerbrey, Columbus, Ohio; University and Bellevue Hospital Medical College, New York, 1903; aged 68; died, Dec. 25, 1940.

John Herbert Leimbach Sr. ● Isleton, Calif.; University of California Medical Department, San Francisco, 1902; aged 63; died, Dec. 1, 1940.

Thomas Duncan Rutherford, Burford, Ont., Canada; University of Toronto Faculty of Medicine, 1905; aged 60; died, Dec. 10, 1940.

John Livingston Dinning ● New York; University and Bellevue Hospital Medical College, New York, 1899; aged 77; died, Dec. 29, 1940.

John Hedley Secord, Sackville, N. B., Canada; McGill University Faculty of Medicine, Montreal, Que., 1896; aged 71; died, Dec. 27, 1940.

Allen Avery Shepard, Sault Ste. Marie, Ont., Canada; University of Toronto Faculty of Medicine, 1898; aged 67; died, Dec. 2, 1940.

William H. Warrick, Philadelphia; University of Pennsylvania Department of Medicine, Philadelphia, 1891; aged 73; died, Dec. 7, 1940.

Landrum Walker Wood ● Slater, S. C.; Atlanta (Ga.) Medical College, 1914; served during the World War; aged 51; died, Dec. 28, 1940.

Louis Adolphus Sholars, Doyline, La.; Medical Department of Tulane University of Louisiana, New Orleans, 1900; aged 65; died, Dec. 7, 1940.

Leonard Niess, Trenton, Ill.; Washington University School of Medicine, St. Louis, 1912; aged 62; died, January 19, of angina pectoris.

John Roger Minahan, Green Bay, Wis.; Rush Medical College, Chicago, 1889; bank president; aged 78; died, January 22, of pneumonia.

Marshall E. Combs, Hazard, Ky.; Kentucky University Medical Department, Louisville, 1906; aged 64; died, January 1, of influenza.

Norman Wilfred Rogers, Barrie, Ont., Canada; University of Toronto Faculty of Medicine, 1910; aged 55; died, Dec. 17, 1940.

Morgan Walcott, San Pedro, Calif.; University and Bellevue Hospital Medical College, New York, 1907; aged 74; died, Dec. 26, 1940.

William H. Grattan, Galatia, Ill.; St. Louis College of Physicians and Surgeons, 1897; aged 68; died in January of pneumonia.

Grattan B. Crowe, El Paso, Texas; Medical College of Alabama, Mobile, 1887; aged 75; died, Nov. 1, 1940, in a local hospital.

Alfred H. Hedderly, Los Angeles; Indiana Medical College, Indianapolis, 1875; aged 85; died, Dec. 29, 1940, of heart disease.

Horace A. Hadley, Chicago; Chicago Physio-Medical Institute, 1889; aged 75; died, January 25, of coronary heart disease.

Edward Franklin Larkins, Los Angeles; Beaumont Hospital Medical College, St. Louis, 1889; aged 85; died, Dec. 16, 1940.

Fayette J. Morton, Cleveland; Long Island College Hospital, Brooklyn, 1881; aged 88; died, January 16, of senility.

Albert W. Wilcox, Laredo, Texas; Texas Medical College and Hospital, Galveston, 1880; aged 83; died, Dec. 24, 1940.

CORRECTION

Dr. William Judson Martin Is Not Dead.—The report of the death of Dr. William Judson Martin of Kokomo, Ind., which appeared in THE JOURNAL, March 15, page 1177, was erroneous. Dr. Martin is alive and well and practicing at Kokomo. The source of our information was the *Journal of the Indiana State Medical Association* for January.

Bureau of Investigation

MISBRANDED "PATENT MEDICINES"

Abstracts of Notices of Judgment Issued by the Food and Drug Administration of the United States Department of Agriculture

[EDITORIAL NOTE.—The abstracts that follow are given in the briefest possible form: (1) the name of the product; (2) the name of the manufacturer, shipper or consigner; (3) the composition; (4) the type of nostrum; (5) the reason for the charge of misbranding and (6) the date of issuance of the Notice of Judgment—which is considerably later than the date of the seizure of the product and somewhat later than the conclusion of the case by the Food and Drug Administration.]

Anti-Rheumatic Ointment.—Modern Drugs, Inc., Philippi, W. Va. Composition: sodium salicylate, methyl salicylate, capsicum, turpentine, volatile oils (including camphor, menthol and cajuput) in a petrolatum base. Fraudulently represented as an effective antirheumatic, a relief for pain and swellings and treatment for pneumonia, lumbago, pleurisy, influenza and some other things.—[*N. J. 30978; August 1940.*]

Catalyn.—Royal Lee, trading as Vitamin Products Co., Milwaukee. Composition: essentially a mixture of milk sugar, wheat starch, cellulose, nitrogenous matter, fatty acids, saponifiable oil and liquid petrolatum, with small amounts of compounds of iron, aluminum, calcium and sodium, and phosphates. Biologic examination showed it contained no detectable quantities of vitamins A, C and D and no significant amounts of vitamins B and G. Misbranded because of false claims as to vitamin content and because fraudulently represented as "nature's source of vitality" and as competent to prevent insomnia and correct overweight, underweight and (as supplementary treatment) pernicious anemia, backwardness in children, cystitis, dropsy, goiter, hardening of the arteries, heart disorders, pneumonia, Bright's disease, prostatic enlargement, stomach ulcers, female disorders and many other things.—[*N. J. 30999; August 1940.*]

Dermataas Tablets.—Crescent-Kelvan Co., Philadelphia. Composition: claimed on label to contain 1/60 grain of arsenic sulfide per tablet. This claim was declared false and misleading as each tablet contained 1/50 grain of this substance. Hence the product was declared misbranded.—[*N. J. 30990; August 1940.*]

Hagloges.—Haver-Glover Laboratories, Kansas City, Mo. Composition: not reported. Misbranded because fraudulently represented as an antiseptic and disinfectant and effective in the treatment of septic, catarrhal and gangrenous wounds and mucous membranes and effective as an irrigant for wounds and body cavities.—[*N. J. 30989; August 1940.*]

Meth-O-Sel.—Crescent-Kelvan Co., Philadelphia. Composition: a liniment containing camphor, methyl salicylate and oleoresin of capsicum with turpentine and croton oil indicated. Fraudulently represented as a remedy for neuritis, rheumatism, pleurisy, lumbago, backache, sciatica and other conditions involving pain.—[*N. J. 30990; August 1940.*]

Musclefex Rubbing Lotion.—Beacon Laboratories, Inc., Dover, Del. Composition: essentially alcohol (10.3 per cent by volume), oil of turpentine, camphor, a resin such as capsicum, a gum, and water. For lumbago, rheumatic and arthritic manifestations, stiffness, aching feet, and pains following fractures. Fraudulent therapeutic claims.—[*N. J. 30972; August 1940.*]

Neutro-Plasm.—Neutro-Plasm Foundation, Detroit. Composition: essentially plant drugs including a bitter and a laxative, with alcohol and water. Fraudulently represented, among other things, to attack or destroy dead or abnormal tissue or organisms and to check various forms of cancer.—[*N. J. 30991; August 1940.*]

Pixine Ointment.—Pixine Co., Troy, N. Y. Composition: essentially volatile oils including those of turpentine, origanum and juniper, with a small amount of ichthammol in a petrolatum and hydrous wool fat base. Fraudulently represented as a cure for varicose and indolent ulcers, scrofulous and inflammatory swellings, all cuts, carbuncles, boils, hemorrhoids, psoriasis, septic wounds, pneumonia and other respiratory inflammations; bed sores, erysipelas, abscesses, eczema and some other things.—[*N. J. 30986; August 1940.*]

Pixine Pile Remedy.—Pixine Co., Troy, N. Y. Composition: essentially tannic acid, ichthammol and volatile oils including turpentine, in a base of petrolatum and fatty acids. Fraudulently represented as a cure for internal and external hemorrhoids, fistula, anal fissure and all inflammatory conditions of the rectum.—[*N. J. 30986; August 1940.*]

Prescription A Compound.—Modern Drugs, Inc., Philippi, W. Va. Composition: essentially extracts of plant drugs, including an alkaloid-bearing drug, with sodium salicylate, alcohol, sugar and water. Fraudulently represented as an effective treatment for fever, pneumonia, measles, "summer flu," pleurisy, tonsillitis, mumps, colds and some other things.—[*N. J. 30978; August 1940.*]

V. E. T. Skin Remedy.—Crescent-Kelvan Co., Philadelphia. Composition: water, alcohol, a gum and a minute amount of phenol. Misbranded because alcohol presence and amount not declared on the label; further misbranded because fraudulently represented as a treatment for skin irritations, eczema and itch.—[*N. J. 30990; August 1940.*]

Correspondence

DICTION AND ABBREVIATION IN MEDICAL WRITING

To the Editor:—In looking over current medical literature one is impressed with the free use of abbreviations such as E. K. G., W. B. C., B. M. R. and P. S. P. One is also impressed with the careless use of English in the form of such expressions as "acute abdomen," "acute ears" and "no pathology found."

As a matter of fact, pathology is a science, not a disease state of an organ. What these writers really mean is acute abdominal disease, acute otic disease, no morbid anatomy found. "Morbid anatomy" was a favorite expression of Osler's.

E. K. G. may have a Teutonic flavor. Whether the original article describing the instrument was written in Dutch or German I do not know—probably it was the latter language. I can see no special harm in using abbreviations indicated by the original language in which they occurred.

I wonder how Dr. Spillman feels about the common word "leukocyte." Its usual spelling is the anglicized "Leucocyte." As for "poikilocyte," it is hard to say whether that has a Teutonic flavor or whether one is attempting to use the original Greek. The correct spelling of the word is "poecilocyte," a form which one rarely sees in print.

Then there are such atrocities as "taking a patient to surgery" when the operating room is meant; and "the patient has no temperature," when what is meant is that the patient has no fever. The only place where no temperature occurs, so far as I am aware, is in interstellar space.

Slang is all right in its place, but when one attempts to write a scientific paper one at least ought to use English.

MARCUS WARD LYON JR., M.D., South Bend, Ind.

VITAMIN K AND BLOOD TRANSFUSIONS

To the Editor:—In view of the widespread use of vitamin K products, this preliminary report seems to be justified, especially because a cursory perusal of the literature failed to disclose a similar observation.

It was thought that the patient on whom I operated for acute hemorrhagic pancreatitis might need a blood transfusion. Dr. J. J. Kearns, the head of the laboratories at the St. Elizabeth Hospital, found that the serum of the patient, who belonged to group B, agglutinated red blood corpuscles not only of an A donor but also of those belonging to groups B and O. A search for the cause of this strange condition disclosed that this patient, as well as others whose blood showed a similar behavior, had been given intramuscularly 3 mg. of a synthetic vitamin K product. A checkup two weeks after the first blood test showed that the recipient's serum no longer agglutinated the red blood corpuscles of the universal donor whose blood was incompatible at the first examination. In other words, the checkup showed that the strange behavior of the recipient's blood apparently caused by vitamin K was of a transient nature.

The mechanism of this phenomenon is now being investigated. Further observations will show whether the effect of vitamin K products on the agglutinating properties of the recipient's serum is a rule or an exception. Even if the latter is the case, the fact must be borne in mind that the administration of vitamin K products may under certain circumstances interfere with the selection of a suitable donor and/or preclude a blood transfusion. It follows that vitamin K products should not be prescribed without strict indications, particularly if a blood transfusion is contemplated.

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Annual Report on Schools for Occupational Therapists, Physical Therapists, and Clinical Laboratory Technicians

A LIST AND DESCRIPTION OF THE SCHOOLS APPROVED BY THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

The Council on Medical Education and Hospitals has been authorized by the House of Delegates of the American Medical Association to maintain standards and publish lists of approved training schools for clinical laboratory technicians, physical therapists and occupational therapists. Heretofore the lists have been published annually in the Hospital Number of THE JOURNAL. To keep these lists up to date entails constant evaluation of the training programs through inspection and correspondence.

The inspection of technical schools is carried out in conjunction with inspections of the intern and residency training programs conducted by hospitals in the same or neighboring communities.

SCHOOLS OF OCCUPATIONAL THERAPY

The Essentials of an Acceptable School of Occupational Therapy were adopted by the American Medical Association at the Atlantic City session in June 1935. The inspection of occupational therapy schools and the formulation of standards were made following a resolution designed for these purposes and presented to the House of Delegates of the American Medical Association by Dr. J. Gurney Taylor of Wisconsin at the Milwaukee session in June 1933. The Board of Trustees recommended that the Council on Medical Education and Hospitals undertake the survey, promulgate standards and maintain a list of acceptable schools. The revised Essentials were published in THE JOURNAL, March 26, 1938.

Special interest is focused now in differentiating between the so-called technicians in diversional therapy and those trained students who can accomplish therapeutic results by a scientifically planned program of occupation. This program does not stop with the arts and crafts, but it includes all fields of work and vocations. Special emphasis is placed on selecting an activity which will encourage recovery and complete reutilization of the nervous, muscular and bony parts of the body. Part of the occupational therapist's armamentarium is found to overlap into the field of physical therapy. This type of technician is trained to work under the direction of a physician and is capable of suggesting programs designed to recreate specific functions of the human body or to encourage recovery of impaired functions. It is, therefore, not a device to divert one's attention but a therapy designed to hasten complete recovery.

Summarizing the statistics reported by the six approved occupational therapy schools, we find that one and preferably two years of college training is necessary for entrance to these schools. Five schools have a curriculum of three years' duration while one offers a two year training program. Four hundred and twenty-five students were enrolled in 1940, but it is impossible at present to determine how these students are distributed or how many are graduated each year. The annual tuition for this training averages about $240.

Inquiries concerning registration should be directed to the American Occupational Therapy Association, 175 Fifth Avenue, New York City.

APPROVED SCHOOLS OF OCCUPATIONAL THERAPY

Boston School of Occupational Therapy, 7 Harcourt Street, Boston.—Organized in 1918. Incorporated in 1921 as a nonprofit institution. Control is under a board of twenty-nine trustees. The faculty is composed of thirty-nine regular members, thirty-seven lecturers and thirteen extramural instructors, a total of eighty-nine. The educational requirement is one year of college. The duration of the course is three academic years. A total of twenty-one hospitals and other institutions is used in practice training. The tuition fee is $300 a year. At present seventy-six students are enrolled. Students are admitted in September of each year. The director is Mrs. John A. Greene.

Kalamazoo State Hospital School of Occupational Therapy, Kalamazoo, Mich.—Organized in 1922. Governed by a joint committee of Kalamazoo State Hospital and Western State Teachers College, Kalamazoo. Affiliated with Western State Teachers College in 1936. The faculty includes twenty-one instructors in the hospital and nine in the college, eighteen lecturers and eight extramural instructors, fifty-six in all. Two courses are offered: the diploma course of twenty-seven consecutive months requiring for admission one year of college, and a five year course requiring graduation from an accredited high school and leading to a B.S. degree from Western State Teachers College. The school is affiliated for practice training with twelve hospitals and other institutions. The minimum cost of the diploma course is $467. The student pays the regular college fee for courses at Western State Teachers College. Twenty-eight students are now enrolled in the course. Students are admitted in April and October. The director is Miss Marion R. Spear, B.S., O.T.Reg.

St. Louis School of Occupational and Recreational Therapy, 4567 Scott Avenue, St. Louis.—Organized in 1918. Conducted by the Missouri Association for Occupational Therapy and governed by a board of trustees. Affiliated with the University College of Washington University. The faculty includes thirty-seven instructors and lecturers and twenty extramural instructors, a total of fifty-seven. Two courses are offered: the diploma course of three academic years requiring for admission two years of college work, and a five year course requiring graduation from an accredited high school and leading to a B.S. degree from Washington University. Practice training is given in a total of twenty affiliated hospitals and other institutions. The annual tuition is $325. The present enrolment is thirty students. Students are admitted in September of each year. The director is Miss Geraldine R. Lermit, A.B., Ph.M., O.T.Reg.

Philadelphia School of Occupational Therapy, 419 South 19th Street, Philadelphia.—Organized in 1918. Incorporated in 1923 as a nonprofit organization. Management is vested in a board of directors. The faculty includes twenty-seven instructors in theoretical subjects, eight in therapeutic occupations and nineteen extramural instructors, fifty-four in all. The entrance requirement is one year of college. The course covers three academic years. Practice training is given in a total of twenty affiliated hospitals and other institutions. The total tuition is $650. At present ninety-six students are enrolled in the course. Students are admitted in September. The director is Miss Helen S. Willard, A.B., O.T.Reg.

Milwaukee-Downer College, Department of Occupational Therapy, 2512 East Hartford Avenue, Milwaukee.—Course in occupational therapy organized in 1913. Management of the college is vested in a board of thirty-two trustees. In addition to the regular college faculty, there are forty-three lecturers. Two courses are offered: the diploma course of three academic years requiring for admission one year of college and a five year course requiring graduation from an accredited high school and leading to a B.S degree. Practice training is given in fifteen affiliated hospitals and other institutions. The annual tuition fee for the diploma course is $250 and for the degree course $230. The present enrolment is ninety-eight. Students are admitted in September. Miss Henrietta McNary, O.T.Reg., is director of occupational therapy.

University of Toronto, Department of University Extension, Toronto, Ont., Canada.—Course in occupational therapy organized in 1926. The regular occupational therapy faculty numbers thirty and in addition there are twenty extramural instructors, a total of fifty. The admission requirement is five subjects of honor matriculation (equivalent to one year of college). The duration of the course is twenty-four months. Hospitals and other institutions affiliated for practice training number nineteen. The annual tuition fee is $175. At present ninety-seven students are enrolled in the course. Students are admitted in September. The supervisor of the course is Miss Helen P. LeVesconte

SCHOOLS FOR PHYSICAL THERAPY TECHNICIANS

The first list of approved schools for physical therapy technicians appeared in THE JOURNAL, Aug. 29, 1936, following the formulation of the Essentials by the Council on Medical Education and Hospitals and their adoption by the House of Delegates of the American Medical Association.

A more detailed questionnaire was sent to each of the approved schools for physical therapy technicians this year, and returns have been received from all. Today's graduate has had a mean average of twelve months' training in physical therapy in addition to the preliminary training of four years of physical education or three years training in nursing. Five schools will admit students on completion of sixty semester hours of college work. This represents only one third of the approved schools.

SCHOOLS APPROVED FOR TRAINING PHYSICAL THERAPY TECHNICIANS

By the Council on Medical Education and Hospitals

Name and Location of School	Medical Director	Technical Director	Entrance Requirement	Duration of Course	Time of Admission	Maximum Enrolment	Tuition	Certificate, Diploma, Degree
California Hospital, Los Angeles [1,a]	Grace P. Jennings, M.D.	Marion D. Campbell, R.N.	(a) R.N. (b) Grad. phys. ed. (c) 2 yrs. coll.	18 mos.	Jan. & July	6	$200	Certificate
Children's Hospital, Los Angeles [2]	John C. Wilson, M.D.	Grace L. Williams, R.N.	(a) R.N. (b) Grad. phys. ed. (c) 2 yrs. coll.	15 mos.	Sept.	14	$150	Diploma
Walter Reed General Hospital Washington, D. C.[3]	B. A. Strickland, Jr., Capt., M.C.	Emma E. Vogel	Grad. phys. ed.	12 mos.	Sept.	15	None	Certificate
Northwestern University Medical School, Chicago [4,a]	John S. Coulter, M.D.	Gertrude Beard, R.N.	(a) R.N. (b) Grad. phys. ed. (c) 2 yrs. coll.	9 mos.	Oct.	12	$200	Certificate
Bouvé-Boston School of Physical Education, Boston [5]	Howard Moore, M.D.	Constance K. Greene	High sch. grad.	3 and 4 yrs.[b]	Sept.	12	$400 yr.	Diploma or B.S.
Harvard Medical School, Boston [6]	Frank R. Ober, M.D.	Janet B. Merrill	(a) R.N. (b) Grad. phys. ed.	9 mos.	Jan. & Sept.	20	$150	Certificate
Boston University, Sargent College of Physical Education, Cambridge, Mass.[7]	To be appointed	Lucille W. Fuller	High sch. grad.	4 yrs.	Oct.	24	*	B.S.
Posse Institute, Kendal Green, Mass.[8]	.....	Lucy G. Marshall	High sch. grad.	3 yrs.	Sept.	15	$400 yr.	Diploma
Mayo Clinic, Rochester, Minn.[9,a]	Frank H. Krusen, M.D.	Carl Moe, R.N.	(a) R.N. (b) Grad. phys. ed.	12 mos.	Oct.	20	None	Certificate
St. Louis University School of Nursing, St. Louis [10,a]	Alexander J. Kotkis, M.D.	Sister M. Consella, R.N.	High sch. grad.	4 yrs.	Feb. & Sept.	4	$250 yr.	B.S.
University of Buffalo School of Nursing, Buffalo [11,a]	George G. Martin, M.D.	Edna Beaver, R.N.	(a) R.N. (b) Grad. phys. ed. (c) 2 yrs. coll.	12 mos.	Jan. & Sept.	10	$375	Certificate
Hospital for Ruptured and Crippled, New York City [12,a]	Kristian G. Hansson, M.D.	Ethel M. Willmer	(a) R.N. (b) Grad. phys. ed. (c) 2 yrs. coll.	9 mos.	Sept.	20	$300	Diploma
D. T. Watson School of Physiotherapy (affiliated with University of Pittsburgh School of Medicine), Leetsdale, Pa.[13,a]	Jessie Wright, M.D.	Dorothy E. Lovdahl	(a) Grad. phys. ed. (b) 2 yrs. premed.	2 yrs.	Sept.	8	None	Diploma or B.S.
College of William and Mary, Richmond, Va.[14]	Thomas Wheeldon, M.D.	Alice Jones	(a) R.N. (b) Coll. grad.	9 mos.	Sept.	10	$200	Certificate or B.S.
University of Wisconsin Medical School, Madison [15,a]	Ernst A. Pohle, M.D.	Margaret Kohli and Martha Lewis	(a) R.N. (b) Grad. phys. ed.	12 mos.	July	10	Univ. fees	Certificate

AFFILIATED CLINICAL FACILITIES

1. Glendale Sanitarium and Hospital, Glendale, and Los Angeles County Hospital, Los Angeles.
2. Glendale Sanitarium and Hospital, Glendale, and Cedars of Lebanon Hospital, Hospital of the Good Samaritan, Los Angeles County Hospital, and Presbyterian Hospital—Olmsted Memorial, Los Angeles.
3. Health School for Crippled Children, Washington, D. C.
4. Christopher School for Crippled Children, Michael Reese Hospital, Passavant Memorial Hospital, St. Luke's Hospital, and Shriners Hospital for Crippled Children, Chicago.
5. Boston City Hospital, Children's Hospital, Massachusetts General Hospital, and Robert Breck Brigham Hospital, Boston; Cambridge Hospital, Cambridge; and Newton Hospital, Newton.
6. Children's Hospital, Harvard Infantile Paralysis Commission, Industrial School for Crippled and Deformed Children, Massachusetts General Hospital, Peter Bent Brigham Hospital, and Robert Breck Brigham Hospital, Boston, and Cambridge Hospital, Cambridge.
7. McLean Hospital, Belmont; Industrial School for Crippled and Deformed Children, Massachusetts General Hospital, Massachusetts Memorial Hospital, Massachusetts State Hospital, and Perkins Institute for the Blind, Boston; and Cambridge Hospital, Cambridge.
8. Ring Sanatorium and Hospital, Arlington; Beth Israel Hospital, Boston City Hospital, Carney Hospital, Children's Hospital, Industrial School for Crippled and Deformed Children, Massachusetts General Hospital, and Perkins Institute for the Blind, Boston; and Cambridge City Hospital, Cambridge.
9. Colonial Hospital, and St. Mary's Hospital, Rochester.
10. Firmin Desloge Hospital, St. Louis.
11. Edward J. Meyer Memorial Hospital, and School for Crippled Children, Buffalo.
12. New York Hospital, New York City.
13. Allegheny General Hospital, Children's Hospital, Elizabeth Steel Magee Hospital, Falk Clinic, Industrial Home for Crippled Children, and St. Francis Hospital, Pittsburgh.
14. University of Virginia Hospital, Charlottesville, and Medical College of Virginia Hospital Division, Stuart Circle Hospital, and Wheeldon Clinic, Richmond.
15. State of Wisconsin General Hospital and Wisconsin Orthopedic Hospital for Children, Madison.

FOOTNOTES

a. Male students are admitted.
b. Four-year course leads to B.S. degree from Simmons College.
c. $432 a year for first two years; $385 a year for last two years.

During 1940 there were 135 students who were graduated, while about 140 were in training and expect to be graduated this year. The maximum enrolment, under the present conditions, totals 200 students when one school, that has special classes, is given credit for two groups of students. The tuition for this training ranges from nothing to $400. The mean tuition is $200, while the average is slightly less than that amount.

Correlating last year's graduates in physical therapy with the number of medical students graduated annually, a ratio of one physical therapist to thirty-eight physicians is obtained.

The Council on Physical Therapy of the American Medical Association has appointed a committee to study and revise the curriculum and minimum essentials for training schools. It is hoped that these new standards will be ready for publication by next fall.

Inquiries concerning registration should be addressed to the American Registry of Physical Therapy Technicians, 30 North Michigan Avenue, Chicago.

SCHOOLS FOR CLINICAL LABORATORY TECHNICIANS

The original survey of some 200 schools for clinical laboratory technicians was published in THE JOURNAL, Aug. 29, 1936, together with the first list of approved schools. Essentials had been formulated by the Council on Medical Education and Hospitals with the cooperation of the American Society of Clinical Pathologists and ratified by the House of Delegates.

The Council voted in 1937 to increase the admission requirement from one to two years of college work including credits in the basic sciences of chemistry, biology and physics. At present graduate nurses may be accepted for enrolment, although it has been proposed that only college students with special qualifications be considered eligible for admission to these schools. It is expected that final action on this matter will be taken within the current year.

Returns from all the approved schools reveal that 701 students completed an approved course of training last year. This is equivalent to about one technician being graduated to each seven medical students that are graduated during the same period. The maximum number of students that these schools admit is 1,029 each year. If an estimate is based on the number of laboratory personnel that could act as instructors, between 1,200 and 1,500 technicians could be trained each year in conformity with the present minimum essentials. This does not mean that 1,500 students could be trained as efficiently as 700 are being trained at present. It does mean that if every graduate technician employed in the laboratories of approved schools were used as an instructor, no matter how little experience or teaching ability she had, it would be possible to train this number each year.

With the present returns, it is impossible to determine how many students are preparing to enter these schools next year. Potentially, every junior college and university is preparing one or more students for this field.

Preliminary training required before entering the hospital laboratory consists of two years of college work for over half of the approved schools, while a little over one third of the schools demand a college degree as a prerequisite. The majority of these curriculums (62 per cent) offer training of twelve months' duration, while only 16 per cent of the schools offer eighteen months or more. Attention should be drawn to those approved schools admitting students on completion of high school. These have a curriculum extending from four to five years.

Inquiries concerning registration should be directed to the Registry of Medical Technologists, Ball Memorial Hospital, Muncie, Indiana.

Essentials of an Acceptable School for Clinical Laboratory Technicians

I. ORGANIZATION

1. Acceptable schools for training laboratory technicians may be conducted by universities, colleges, hospitals or public health laboratories.

2. The Council has promulgated standards for this type of training to supply physicians, hospitals and prospective students with reliable information and for the protection of the public.

3. Responsibility for courses in hospitals should be placed on the hospital administration rather than the laboratory director. In colleges and universities this responsibility is on the controlling board, as for other courses.

4. Resources for continued operation of the school should be insured through regular budgets, gifts or endowments; but not entirely through students' tuition fees. Experience has shown that commercial schools operated for profit frequently do not adhere to proper ethical and education standards and are, therefore, not acceptable.

5. There must be available transcripts of high school, college work and other credentials. Attendance and grades of students shall be carefully recorded, by means of which an exact knowledge may be obtained regarding each student's work.

6. At least two or more students should be enrolled in each class.

II. FACULTY

7. The school should have a competent teaching staff. The director must be a graduate in medicine and a pathologist of recognized ability. He shall take part in and be responsible for the actual conduct of the training course. He shall be in daily attendance for sufficient time to supervise properly the laboratory work and teaching.

8. In laboratory practice the enrolment shall not exceed one student to each member of the teaching staff. The staff should include not less than one salaried instructor who is a registered technician or eligible for registration in addition to the laboratory director.

III. CLINICAL FACILITIES

9. Each student should receive practice training, adequate in kind and amount, under competent supervision, in a hospital laboratory. The hospital should be registered by and be otherwise acceptable to the Council on Medical Education and Hospitals of the American Medical Association and have a minimum of 2,000 yearly admissions. There should be a minimum of 15,000 tests and examinations carried out in the laboratory department annually.

10. Adequate space, light and modern equipment shall be provided in the laboratory department. A library containing up-to-date references, texts and scientific periodicals pertaining to clinical laboratory work and pathology should be maintained.

11. Satisfactory record systems shall be provided for all work carried on in the department. Monthly and annual classifications of the work of the department should be prepared.

IV. CURRICULUM

12. A. Candidates for admission should be able to satisfy one of the following requirements:

1. Two years of college work, including chemistry, biology and physics from an accredited college or university.
2. Graduation from a school of nursing recognized by the state board of nurse examiners, and in addition college chemistry.

B. The course of training shall be not less than twelve months in duration and shall include the following divisions:

1. Biochemistry.
2. Hematology.
3. Bacteriology.
4. Parasitology.
5. Histologic technic.
6. Serology.

The instruction shall include:

1. Text assignments.
2. Lectures.
3. Demonstrations.
4. Quizzes.
5. Examinations—written, oral and practical.

V. ETHICS

13. Exorbitant fees and commercial advertising shall be considered unethical.

14. Schools conducted primarily for the purpose of substituting students for paid technicians will not be considered for approval.

Schools Approved for Training Clinical Laboratory Technicians by the Council on Medical Education and Hospitals

Under the column headed "Name and Location of School" enclosures in parentheses denote affiliations. The abbreviation *Br. fee*, under "Tuition," indicates breakage fee.

Name and Location of School	Director	Entrance Requirement	Duration of Course	Time of Admission	Maximum Enrolment	Tuition	Certificate, Diploma, Degree
ARKANSAS							
University of Arkansas College of Medicine (University Hospital), Little Rock	E. L. Wilbur, M.D.	2 yrs. coll.	12 mos.	Sept.	4	$100	Certificate
CALIFORNIA							
Children's Hospital, Los Angeles	A. Wright, M.D.	Coll. degree	12 mos.	Quarterly	3	None	None
College of Medical Evangelists (White Memorial Hospital), Los Angeles	O. B. Pratt, M.D.	2 yrs. coll.	12 mos.	Sept.	6	$100	Certificate
Los Angeles County Hospital, Los Angeles	N. Evans, M.D.	Coll. degree	15 mos.	Monthly	12	Br. fee	Certificate
Collis P. and Howard Huntington Memorial Hospital, Pasadena	A. G. Foord, M.D.	Coll. degree	12 mos.	July	4	$10 (Br. fee)	Certificate
Mary's Help Hospital, San Francisco	Z. E. Bolin, M.D.	2 yrs. coll.	18 mos.	Varies	3	$10 (Br. fee)	Certificate
Mt. Zion Hospital, San Francisco	C. Weiss, M.D.	Coll. degree	12 mos.	Quarterly	4	$100	None
University of California Hospital, San Francisco	I. C. Schumacher, M.D.	2 yrs. coll.	12 mos.	Varies	4	None	None
COLORADO							
Children's Hospital, Denver	E. I. Dobos, M.D.	Coll. grad.	12 mos.	Sept.	..	None	Certificate
University of Denver School of Science and Engineering, Denver [1]	R. E. Nyswander, Dean	High sch. grad.	4 yrs.	Jan., March & Sept.	60	$225 yr.	B.S.
FLORIDA							
Florida State Hospital, Chattahoochee	E. H. Ruediger, M.D.	2 yrs. coll.	12 mos.	June	4	None	Diploma
GEORGIA							
Grady Hospital, Atlanta	E. W. Townsend, M.D.	Coll. degree	12 mos.	June & Sept.	12	None	Certificate
Piedmont Hospital, Atlanta	W. B. Matthews, M.D.	Coll. degree	12 mos.	Jan. & July	3	None	Certificate
University of Georgia School of Medicine, Augusta [2]	E. R. Pund, M.D.	Coll. degree	12 mos.	Sept.	2	$100	Certificate
Emory University Graduate School, Emory University [3]	R. R. Kracke, M.D.	Coll. degree	18 mos.	Sept.	14	$225 & $50 (Lab. fees)	M.S.
ILLINOIS							
Michael Reese Hospital, Chicago	K. M. Howell, M.D.	2 yrs. coll.	12 mos.	Monthly	13	$100	Certificate
Mt. Sinai Hospital, Chicago	I. Davidsohn, M.D.	2 yrs. coll.	18 mos.	Varies	8	$180	Diploma
Northwestern University Medical School (Passavant Memorial Hospital), Chicago	O. E. Hepler, Ph.D.	2 yrs. coll.	12 mos.	Monthly	10	$50	Certificate
Provident Hospital, Chicago	J. H. Lewis, M.D.	2 yrs. coll.	12 mos.	Varies	7	$100	Certificate
Evanston Hospital, Evanston	E. L. Benjamin, M.D.	Coll. degree	12 mos.	Feb. & July	4	$100	Certificate
St. John's Hospital, Springfield	H. M. Steen, M.D.	2 yrs. coll.	12 mos.	Quarterly	8	$50	Certificate
St. Therese's Hospital, Waukegan	E. Nora, M.D.	2 yrs. coll.	12 mos.	Sept.	3	$100	Diploma
INDIANA							
Indiana University School of Medicine, Indianapolis [4]	C. G. Culbertson, M.D.	2 yrs. coll.	12 mos.[c]	July	5	None	Certificate
Methodist Hospital, Indianapolis	H. M. Banks, M.D.	Coll. degree	12 mos.	July	6	None	Certificate
South Bend Medical Laboratory (Epworth Hospital), South Bend	A. S. Giordano, M.D.	2 yrs. coll.	18 mos.	Varies	2	$125 yr.	None
KANSAS							
Bethany Hospital, Kansas City	W. W. Summerville, M.D.	B.S.	16 mos.[b]	Feb., Aug. & Nov.	4	None	Certificate
University of Kansas Hospitals, Kansas City	H. R. Wahl, M.D.	Coll. degree	12 or 18 mos.[c]	Jan. & July	14	None	Certificate
St. Francis Hospital, Wichita	C. A. Hellwig, M.D.	2 yrs. coll.	12 mos.	Sept.	6	$150	Diploma
Wichita Hospital, Wichita	L. C. Murphy, M.D.	2 yrs. coll.	12 mos.	Fall & Spring	2	$100	Certificate
KENTUCKY							
St. Joseph's Hospital, Lexington [5]	F. S. Maxwell, M.D.	2 yrs. coll.	12 mos.	Jan. & Sept.	5	$150 & $10 (Br. fee)	Certificate
University of Kentucky, Lexington [6]	M. Schernago, D.V.M.	High sch. grad.	4 yrs.	Feb. & Sept.	14	$100 yr.[d] & $5 (Br. fee)	B.S.
Kentucky State Department of Health, Louisville [7]	L. H. South, M.D.	2 yrs. coll.	Sept.		20	$200 & $10 (Br. fee)	Diploma
St. Joseph Infirmary, Louisville	H. M. Weeter, M.D.	2 yrs. coll.	12 mos.	Sept.	4[e]	$150	None
St. Mary and Elizabeth Hospital, Louisville	H. M. Weeter, M.D.	2 yrs. coll.	12 mos.	Jan. & July	3	$120	Certificate
LOUISIANA							
Loyola University, New Orleans [8]	J. G. Arnold, Jr., Ph.D.	High sch. grad.	5 yrs.	Sept.	66	Univ. fees	B.S.
T. E. Schumpert Memorial Sanitarium, Shreveport	W. P. Butler, M.D.	2 yrs. coll.	12 mos.	Feb.	2	$50	Certificate
MAINE							
Central Maine General Hospital, Lewiston [9]	J. Gottlieb, M.D.	B.S.	15 mos.	Quarterly	5	$100	Certificate
MARYLAND							
Mercy Hospital, Baltimore	H. T. Collenberg, M.D.	2 yrs. coll.	20 mos.	Sept.	14	$150 & $10 (Br. fee)	Certificate
MASSACHUSETTS							
Simmons College, Boston [10]	C. M. Hilliard, A.B.	Coll. grad.	12 mos.	Feb. & Sept.	4	$200	Diploma
Mercy Hospital, Springfield	J. E. Dwyer, M.D.	Coll. degree	12 mos.	Quarterly	5	Br. fee	Certificate
Worcester City Hospital, Worcester	E. H. Goodale, M.D.	2 yrs. coll.	12 mos.	Every 2 mos.	6	None	Diploma
Worcester State Hospital, Worcester	J. M. Looney, M.D.	Coll. degree	12 mos.	Jan. & July	2	None	Certificate
MICHIGAN							
Lella Y. Post Montgomery Hospital, Battle Creek	A. A. Humphrey, M.D.	Coll. degree	12 mos.	Jan., June & Aug.	3	$25 (Br. fee)	Certificate
Mercy Hospital, Bay City	W. G. Gamble, Jr., M.D.	2 yrs. coll.	12 mos.	March	2	$150	Certificate
City of Detroit Receiving Hospital, Detroit	O. A. Brines, M.D.	2 yrs. coll.	12 mos.	July & Oct.	6	$100	Certificate
Grace Hospital, Detroit	C. I. Owen, M.D.	2 yrs. coll.	12 mos.	Jan., May & Sept.	9	$150 & $10 (Br. fee)	Certificate
Henry Ford Hospital (Wayne University), Detroit	F. W. Hartman, M.D.	Coll. degree	18 mos.	Varies	12	None	M.S.
Providence Hospital, Detroit	D. H. Kaump, M.D.	Coll. degree	12 mos.	Quarterly	7	$50	Certificate
Wayne University, Detroit [11]	C. W. Creaser, Ph.D.	High sch. grad.	4 yrs.	Sept.	74	Univ. fees	B.S.
Woman's Hospital, Detroit	D. C. Beaver, M.D.	2 yrs. coll.[f]	12 mos.	July & Oct.	5	$100	Certificate or B.S.[g]
Michigan State College, East Lansing [12]	W. Giltner, D.V.M.	High sch. grad.	4 yrs.	Jan., April & Sept.	10	Coll. fees	B.S.
Eloise Hospital—Dr. Wm. J. Seymour Hospital, Eloise	S. E. Gould, M.D.	2 yrs. coll.[f]	18 mos.	July	5	None	B.S.[g]

MINNESOTA							
College of St. Scholastica (St. Mary's Hospital), Duluth	J. J. Grabow, M.D.	High sch. grad.	4 yrs.	Sept.	46	Coll. fees	B.S.
St. Luke's Hospital (Hamline University, St. Paul), Duluth	A. H. Wells, M.D.	2 yrs. coll.	2 yrs.	July	9	Br. fee	B.S.
Minneapolis General Hospital, Minneapolis	F. C. Andrus, M.D.	Coll. grad.[1]	12 mos.	Every 20 days	18	None	None
Swedish Hospital, Minneapolis	C. B. Drake, M.D.	2 yrs. coll.	24 mos.[1]	Aug. & Oct.	5	$125 yr.	Cert. or Dip.
University of Minnesota, Minneapolis[12]	G. T. Evans, M.D.	High sch. grad.	4 yrs.	Quarterly	51	Univ. fees	B.S.
Charles T. Miller Hospital (Macalester College), St. Paul	E. Ikeda, M.D.	2 yrs. coll.	12 mos.	July	6	$110	A.B.
MISSISSIPPI							
Vicksburg Sanitarium, Vicksburg	L. S. Lippincott, M.D.	2 yrs. coll.	24 mos.	Varies	4	$60 (Br. fee)	Certificate
MISSOURI							
Kansas City Health Department Laboratories, Kansas City[14]	V. B. Buhler, M.D.	2 yrs. coll.	18 mos.	Jan. & July	18	Br. fee	Certificate
Menorah Hospital, Kansas City	B. Koritschoner, M.D.	Coll. degree	15 mos.	Varies	6	None	None
Research Hospital, Kansas City	F. C. Narr, M.D.	2 yrs. coll.	12 mos.	Every 2 mos.	6	None	None
St. Joseph Hospital, Kansas City	R. W. Kerr, M.D.	Coll. degree	15 mos.[1]	Varies	12	$25 (Br. fee)	Certificate
St. Luke's Hospital, Kansas City	F. C. Helwig, M.D.	2 yrs. coll.	16 mos.[2]	Every 2 mos.	10	$10 (Br. fee)	None
St. Mary's Hospital, Kansas City	C. G. Leitch, M.D.	Coll. grad.	12 mos.	July	6	$10 (Br. fee)	Certificate
Homer G. Phillips Hospital, St. Louis	S. H. Gray, M.D.	2 yrs. coll.	21-24 mos.	Varies	4	None	None
St. Louis City Hospital, St. Louis	S. H. Gray, M.D.	2 yrs. coll.	15 mos.	Quarterly	5	None	None
St. Louis University School of Nursing, St. Louis[15]	G. O. Broun, M.D.	High sch. grad.	4 yrs.	Sept.	24	Univ. fees	B.S.
MONTANA							
Murray Hospital, Butte	R. F. Peterson, M.D.	3 yrs. coll.	12 mos.	Varies	2	None	B.S.[1]
College of Great Falls, Great Falls[16]	T. F. Walker, M.D.	High sch. grad.	4 yrs.	Sept.	24	Coll. fees	B.S.
Montana State University, Missoula[17]	D. M. Hetler, Ph.D.	High sch. grad.	4 yrs.	Sept.	35	Coll. fees	B.S.
NEBRASKA							
Bryan Memorial Hospital, Lincoln	M. J. Breuer, M.D.	2 yrs. coll.	12 mos.	Feb., June & Sept.	3	$25 (Br. fee)	Diploma
Lincoln General Hospital, Lincoln	G. W. Covey, M.D.	2 yrs. coll.	12 mos.	Quarterly	5	$50	Diploma
University of Nebraska Hospital, Omaha	J. P. Tollman, M.D.	2 yrs. coll.	12 mos.	June & Aug.	6	$75	Certificate
NEW HAMPSHIRE							
Mary Hitchcock Memorial Hospital, Hanover	R. E. Miller, M.D.	3 yrs. coll.	12 mos.	Quarterly	6	$50 (Br. fee)	Certificate
NEW YORK							
Bender Hygienic Laboratory, Albany[18]	J. J. Clemmer, M.D.	2 yrs. coll.	12 mos.	Sept.	15	$200	Certificate
Jewish Hospital, Brooklyn	E. Lederer, M.D.	Coll. degree	18 mos.	Quarterly	7	None	Certificate
Buffalo General Hospital, Buffalo	K. L. Terpian, M.D.	Coll. grad.	13-15 mos.	In summer mos.	12	$50	Certificate
Edward J. Meyer Memorial Hospital, Buffalo	D. K. Miller, M.D.	2 yrs. coll.	12 & 24 mos.	Monthly	10	$25 (Br. fee)	Certificate
University of Buffalo (Edward J. Meyer Memorial Hospital), Buffalo	D. K. Miller, M.D.	High sch. grad.	4 yrs.	Sept.	3	$775 yr.	B.A.
Mary Immaculate Hospital, Jamaica	J. M. Pearce, M.D.	Coll. degree	12 mos.	Oct.	5	$25 (Br. fee)	Certificate
Rochester General Hospital, Rochester	J. A. Gáspár, M.D.	Coll. degree	18 mos.	Varies	13	$225	Diploma
Ellis Hospital, Schenectady	E. Kellert, M.D.	2 yrs. coll.	12 mos.	Sept. & Oct.	8	None	Certificate
Russell Sage College (Samaritan Hospital), Troy	G. H. Klinck, Jr., M.D.	High sch. grad.	4 yrs.	Sept.	14	Coll. fees	B.S.
NORTH CAROLINA							
Duke Hospital, Durham	D. T. Smith, M.D.	2 yrs. coll.	18 mos.	Aug.	20	$75 (Br. & health fees)	Certificate
Watts Hospital, Durham	C. E. Brown, M.D.	2 yrs. coll.	12 mos.	Jan. & July	4	$25 (Br. fee)	Certificate
OHIO							
City Hospital, Akron	I. Catron, M.D.	2 yrs. coll.	12 mos.	July	2	None	Certificate
Ohio University (Mt. Carmel Hospital, Columbus), Athens	F. H. Kreiker, Ph.D.	High sch. grad.	4½ yrs.	Feb. & Sept.	53	Univ. fees	B.S.
Institute of Pathology, Western Reserve University (University Hospitals), Cleveland	H. Goldblatt, M.D.	Coll. grad.[3]	12 mos.	June, July & Aug.	17	$100	Certificate
Mt. Sinai Hospital, Cleveland	B. S. Kline, M.D.	2 yrs. coll.	12 mos.	July & Sept.	6	$250 & $15 (Br. fee)	Certificate
Starling-Loving University Hospital, Columbus	H. L. Reinhart, M.D.	A.B.	12 mos.	Quarterly	9	$100	Certificate
White Cross Hospital, Columbus	R. S. Fidler, M.D.	Coll. degree	12 mos.	Jan., June & Sept.	3	None	Certificate
Huron Road Hospital, East Cleveland	E. Goodsitt, M.D.	2 yrs. coll.	12 mos.	July	6	$100	Certificate
College of Mt. St. Joseph-on-the-Ohio, Mt. St. Joseph[19]	W. M. German, M.D.	High sch. grad.	4 yrs.	Sept.	26	Coll. fees	B.S.
Toledo Hospital, Toledo	B. Steinberg, M.D.	Coll. grad.[4]	12 mos.	Feb. & Sept.	6	$100 & $10 (Br. fee)	Certificate
Youngstown Hospital, Youngstown	G. B. Kramer, M.D.	2 yrs. coll.	12 mos.	Jan.	3	None	Certificate
OKLAHOMA							
St. Anthony's Hospital, Oklahoma City	H. G. Jeter, M.D.	Coll. degree	12 mos.	Varies	4	None	None
State University and Crippled Children's Hospitals, Oklahoma City	H. G. Jeter, M.D.	Coll. degree	12 mos.	Varies	5	None	None
OREGON							
Emanuel Hospital, Portland	H. H. Foskett, M.D.	Coll. degree	12 mos.	Varies	3	$150	None
Good Samaritan Hospital, Portland	C. H. Manlove, M.D.	2 yrs. coll.	12 mos.	Quarterly	5	None	None
Portland Sanitarium and Hospital, Portland	W. C. Hunter, M.D.	2 yrs. coll.	12 mos.	Jan. & July	2	None	Certificate
St. Vincent's Hospital, Portland	T. D. Robertson, M.D.	2 yrs. coll.	12 mos.	April, July & Nov.	4	None	None
University of Oregon Medical School Hospitals and Clinics, Portland	H. P. Lewis, M.D.	2 yrs. coll.	12 mos.	Varies	6	None	None
PENNSYLVANIA							
Abington Memorial Hospital, Abington	J. Elman, M.D.	2 yrs. coll.	16 mos.	Quarterly	7	None	None
Allentown Hospital, Allentown	J. J. Wenner, M.D.	2 yrs. coll.	12 mos.	Varies	2	None	None
Moravian College for Women, Bethlehem[20]	D. R. Corcoran, M.A.	High sch. grad.	4 yrs.	Sept.	56	Coll. fees	B.S.
St. Luke's Hospital, Bethlehem	H. A. Rohrbach, Jr., M.D.	2 yrs. coll.	12 mos.	Sept.	3	$75	Certificate
Bryn Mawr Hospital, Bryn Mawr	M. M. Strumia, M.D.	2 yrs. coll.	15 mos.	Quarterly	5	$120	Certificate
Fitzgerald-Mercy Hospital, Darby	P. J. Kennedy, M.D.	Coll. degree	12 mos.	July & Oct.	3	$25 (Br. fee)	Certificate
Harrisburg Hospital, Harrisburg[21]	G. R. Moffitt, M.D.	2 yrs. coll.	12 mos.	Every 4 mos.	6	None	Certificate
Harrisburg Polyclinic Hospital, Harrisburg	H. H. Van Horn, M.D.	Coll. degree	12 mos.	Varies	2	None	Diploma
Bucknell University (Geo. F. Geisinger Memorial Hospital, Danville), Lewisburg	H. F. Hunt, M.D.	High sch. grad.	4¼ yrs.	Sept.	30	Univ. fees	B.S.
Germantown Dispensary and Hospital, Philadelphia	F. B. Lynch, Jr., M.D.	2 yrs. coll.	12 mos.	Oct.	4	$100	Certificate
Jefferson Medical College Hospital, Philadelphia	C. J. Bucher, M.D.	2 yrs. coll.	16 mos.	Every 2 mos.	6	$100 & $25 (Br. fee)	None
Lankenau Hospital, Philadelphia	S. P. Belman, M.D.	2 yrs. coll.	12 mos.	Feb. & Sept.	2	$50	Certificate
St. Agnes Hospital, Philadelphia	J. W. Love, M.D.	2 yrs. coll.	18 mos.	Sept.	3	$50	Certificate
St. Joseph's Hospital, Philadelphia	L. A. Soloff, M.D.	2 yrs. coll.	12 mos.	Varies	3	$120 & $20 (Br. fee)	Certificate

Schools Approved for Training Clinical Laboratory Technicians—Continued

Name and Location of School	Director	Entrance Requirement	Duration of Course	Time of Admission	Maximum Enrolment	Tuition	Certificate, Diploma, Degree
PENNSYLVANIA—Continued							
Temple University (Temple University Hospital), Philadelphia	F. W. Konzelmann, M.D.	High sch. grad.	4 yrs.	Feb. & Sept.	88	Univ. fees	B.S.
Montefiore Hospital, Pittsburgh	K. Yardumian, M.D.	Coll. grad.	12 mos.	June	4	Hr. fee	Certificate
Albright Hospital (Reading Hospital), Reading	E. D. Funk, M.D.	High sch. grad.	4½ yrs.	Sept.	18	Coll. fees	B.S.
Moses Taylor Hospital, Scranton	C. L. Mattas, M.D.	Coll. grad.	12 mos.	July & Sept.	3	None	Certificate
Scranton State Hospital, Scranton	C. L. Mattas, M.D.	2 yrs. coll.	12 mos.	July, Aug. & Sept.	3	None	Certificate
Wilkes-Barre General Hospital, Wilkes-Barre	W. L. Lanyon, M.D.	2 yrs. coll.	12 mos.	In summer mos.	3	None	Certificate
TENNESSEE							
Knoxville General Hospital, Knoxville	R. H. Monger, M.D.	2 yrs. coll.	12 mos.	July & Dec.	4	Hr. fee	Diploma
John Gaston Hospital (University of Tennessee), Memphis	H. C. Schmeisser, M.D.	Coll. degree	12 mos.	Quarterly	4	None	Certificate
Meharry Medical College (Geo. W. Hubbard Hospital), Nashville	W. H. Grant, M.D.	2 yrs. coll.	2 yrs.[b]	Oct.	4	$100 yr.	Certificate
Nashville General Hospital, Nashville	W. A. DeMonbreun, M.D.	2 yrs. coll.	12 mos.	Jan. & July	2	None	Certificate
TEXAS							
Hotel Dieu Hospital, Beaumont [ss]	H. B. Williford, M.D.	2 yrs. coll.	18 mos.	Jan.	6	$10 (Hr. fee)	None
Baylor University Hospital, Dallas	J. M. Hill, M.D.	2 yrs. coll.	12 mos.	Monthly	13	$100	Certificate
Texas Christian University (Harris Memorial Methodist Hospital), Ft. Worth	J. Andújar, M.D.	High sch. grad.	4 yrs.	Sept.	15	Univ. fees	B.S.
John Sealy Hospital, Galveston	M. Rodansky, M.D.	2 yrs. coll.	12 mos.	Varies	15	$150	Certificate
Robert B. Green Memorial Hospital, San Antonio	W. V. Knoll, M.D.	2 yrs. coll.	12 mos.	Varies	6	$200	Certificate
UTAH							
University of Utah School of Medicine, Salt Lake City [ss]	O. A. Ogilvie, M.D.	High sch. grad.	4 yrs.	Sept.	48	Univ. fees	B.S.
VIRGINIA							
University of Virginia Hospital, Charlottesville	W. E. Bray, M.D.	2 yrs. coll.	12 mos.	Sept.	10	$50 (Hr. fee)	None
Hospital of St. Vincent de Paul, Norfolk	A. F. Strauss, M.D.	2 yrs. coll.	18 mos.	Feb., July & Sept.	6	$180 & $10 (Hr. fee)	Certificate
College of William and Mary, Richmond [ss]	R. C. Beck, M.D.	High sch. grad.	4 yrs.	Sept.	40	$200 yr.[p]	B.S.
Medical College of Virginia Hospital Division, Richmond	J. H. Scherer, M.D.	3 yrs. coll.	18 mos.	Quarterly	10	$150	Certificate
Stuart Circle Hospital, Richmond	R. C. Beck, M.D.	B.S.	12 mos.	Every 4 mos.	3	$250	Certificate [r]
WASHINGTON							
State College of Washington (St. Luke's Hospital, Spokane), Pullman	V. Burke, Ph.D.	High sch. grad.	4½ yrs.	Feb. & Sept.	45	Coll. fees	B.S.
King County Hospital, Seattle	C. B. Jensen, M.D.	2 yrs. coll.	12 mos.	Varies	6	$10	None
Deaconess Hospital, Spokane	G. A. C. Snyder, M.D.	Coll. degree	12 mos.	July, Aug. & Sept.	3	None	Certificate
Sacred Heart Hospital, Spokane	M. M. Patton, M.D.	2 yrs. coll.	12 mos.	Varies	4	None	None
St. Luke's Hospital (State College of Washington, Pullman), Spokane	R. F. E. Stier, M.D.	3½ yrs. coll.[s]	12 mos.	Feb. & Sept.	5	$40	Certificate
St. Joseph's Hospital, Tacoma	C. K. McColl, M.D.	2 yrs. coll.	18 mos.	April & Sept.	2	$30 & $15 (Hr. fee)	Diploma
Tacoma General Hospital, Tacoma [ss]	C. P. Larson, M.D.	2 yrs. coll.	12 mos.	July	5	None	Certificate
WISCONSIN							
St. Francis Hospital, La Crosse	W. E. Bayley, M.D.	2 yrs. coll.	18 mos.	Jan. & July	3	$100 & Hr. fee	Certificate
Madison General Hospital, Madison	L. M. McGary, M.D.	Coll. degree	12 mos.	Oct.	3	None	Certificate
St. Mary's Hospital, Madison	S. B. Pessin, M.D.	2 yrs. coll.	18 mos.	Quarterly	7	$25	Diploma
University of Wisconsin (State of Wisconsin General Hospital), Madison	W. D. Stovall, M.D.	High sch. grad.	4 yrs.	Sept.	110	Univ. fees	B.S.
Milwaukee Hospital, Milwaukee	H. K. B. Allebach, M.D.	2 yrs. coll.	12 mos.	Sept.	5	$25	Certificate
St. Joseph's Hospital, Milwaukee	J. C. Grill, M.D.	2 yrs. coll.	24 mos.	July	5	None	Certificate
Milwaukee County Hospital, Wauwatosa	J. C. Grill, M.D.	2 yrs. coll.	24 mos.	July	6	None	Certificate

NOTES

a. Four-year course leading to a degree is also offered.
b. Including x-ray.
c. Eighteen months' course includes x-ray.
d. Out of state students pay $160 a year.
e. No students admitted during 1941-42.
f. Students from other than affiliated colleges must have degree.
g. From Wayne University, Detroit, or Michigan State College, East Lansing.
h. Completion of three years at University of Minnesota is also acceptable.
i. Includes twelve months training in x-ray.
j. If desired, six months training in x-ray is available.
k. Includes three months in x-ray.
l. From Montana State College, Bozeman, or Montana State University, Missoula.
m. Completion of three years at Western Reserve University is also acceptable; these students are given degree.
n. Graduate nurses with two years of college are admitted. Students may also be admitted after spending three years at the University of Toledo.
o. Covers lunches, materials used, laundry, etc.
p. Out of state students pay $220 a year.
q. Covers breakage fee and materials used.
r. Credit may be applied toward B.S. degree following three years at the College of William and Mary.
s. Students from other than affiliated college must have degree.

ADDITIONAL FACILITIES

1. National Jewish Hospital, and St. Anthony Hospital, Denver; Greeley Hospital, Greeley; Sanatorium of the Jewish Consumptives' Relief Society, Spivak; and St. Joseph's Hospital, Alliance, Neb.
2. Richmond County Board of Health Laboratory, and University Hospital, Augusta.
3. Crawford W. Long Memorial Hospital, Atlanta, and Emory University Hospital, Emory University.
4. Indiana University Medical Center, and State Board of Health Laboratory, Indianapolis.
5. Lexington Clinic, Lexington.
6. City and County Public Health Laboratory, Good Samaritan Hospital, Lexington Clinic, Public Health Center, and Public Service Laboratories, Lexington.
7. Children's Free Hospital, Jewish Hospital, Kosair Crippled Children Hospital, Methodist Deaconess Hospital, Norton Memorial Infirmary, St. Anthony's Hospital, and SS. Mary and Elizabeth Hospital, Louisville.
8. Hotel Dieu—Sisters Hospital, Mercy Hospital, and Dr. J. T. Nix Clinic, New Orleans.
9. New England Medical Center, and Tufts Medical School Laboratories, Boston.
10. Bacteriological Laboratory, Faulkner Hospital, and Massachusetts State Wassermann Laboratory, Boston.
11. City of Detroit Receiving Hospital, Grace Hospital, Providence Hospital, and Woman's Hospital, Detroit, and Eloise Hospital—Dr. Wm. J. Seymour Hospital, Eloise.
12. Woman's Hospital, Detroit; Hurley Hospital, Flint; Blodgett Memorial Hospital, Grand Rapids; Eloise Hospital—Dr. Wm. J. Seymour Hospital, Eloise; and Edward W. Sparrow Hospital, St. Lawrence Hospital, and State Health Laboratories, Lansing.
13. Minneapolis General Hospital, and University Hospitals, Minneapolis.
14. Kansas City General Hospital, Kansas City General Hospital No. 2, and Kansas City Municipal Tuberculosis Hospital, Kansas City.
15. Firmin Desloge Hospital, Mt. St. Rose Sanatorium, and St. Mary's Hospital, St. Louis.
16. Columbus Hospital, Great Falls.
17. Murray Hospital, Butte, and Montana Deaconess Hospital, Great Falls.
18. Anthony N. Brady Maternity Hospital and Memorial Hospital, Albany; Hudson City Hospital, Hudson; and Troy Hospital, Troy.
19. Good Samaritan Hospital, Cincinnati, and Good Samaritan Hospital, Dayton.
20. Allentown Hospital, Allentown State Hospital and Sacred Heart Hospital, Allentown; St. Luke's Hospital, Bethlehem; and Easton Hospital, Easton.
21. Harrisburg Board of Health and Filter Plant Laboratory, Harrisburg.
22. St. Therese Hospital, Beaumont, and St. Mary's Hospital, Port Arthur.
23. Dr. W. H. Groves Latter-Day Saints Hospital, Holy Cross Hospital, St. Mark's Hospital, and Salt Lake County General Hospital, Salt Lake City.
24. Medical College of Virginia Hospital Division, and Stuart Circle Hospital, Richmond.
25. Pierce County Hospital, Tacoma.

Medical Examinations and Licensure

COMING EXAMINATIONS

BOARDS OF MEDICAL EXAMINERS

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

Examinations of boards of medical examiners and boards of examiners in the basic sciences were published in THE JOURNAL, March 15, page 1179.

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: Parts I and II. Various centers, June 23-25. Part III. Various centers, June or July. Exec. Sec., Mr. Everett S. Elwood, 225 S. 15th St., Philadelphia.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY: *Oral.* Part II, Cleveland, May 31-June 1. Final date for filing application is April 1. Sec., Dr. Paul M. Wood, 745 Fifth Ave., New York.

AMERICAN BOARD OF INTERNAL MEDICINE: *Oral.* April, in advance of the meeting of the American College of Physicians and June, in advance of the meeting of the American Medical Association. *Written.* Oct. 20. Final date for filing application is Sept. 1. Sec., Dr. William S. Middleton, 1301 University Ave., Madison, Wis.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: *Oral.* Philadelphia, June 6-7. Sec., Dr. R. Glen Spurling, 404 Brown Bldg., Louisville, Ky.

AMERICAN BOARD OF OPHTHALMOLOGY: *Oral.* Cleveland, May or June; New York, June 2; San Francisco, Aug. 8; Chicago, Oct. 18. *Written.* March 7. Sec., Dr. John Green, 6830 Waterman Ave., St. Louis.

AMERICAN BOARD OF PATHOLOGY: *Oral and Written.* Cleveland, June 2-3. Final date for filing application is May 1. Sec., Dr. F. W. Hartman, Henry Ford Hospital, Detroit.

AMERICAN BOARD OF PEDIATRICS: Chicago, May 18, following the Region III meeting of the American Academy of Pediatrics. Boston, Oct. 12, immediately following the annual meeting of the American Academy of Pediatrics. Sec., Dr. C. A. Aldrich, 707 Fullerton Ave., Chicago.

AMERICAN BOARD OF RADIOLOGY. *Oral.* Cleveland, May 30-June 1. Final date for filing application is April 15. Sec., Dr. Byrl R. Kirklin, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: Written. Part I. Various centers, April 2. Sec., Dr. J. Stewart Rodman, 225 South Fifteenth St., Philadelphia.

Minnesota October Report

Dr. Julian F. Du Bois, secretary, Minnesota State Board of Medical Examiners, reports the written examination for medical licensure held at Minneapolis, Oct. 15-17, 1940. The examination covered 11 subjects and included 60 questions. An average of 75 per cent was required to pass. Forty-eight candidates were examined, all of whom passed. Twelve physicians were licensed to practice medicine by reciprocity and two physicians so licensed by endorsement. The following schools were represented:

School	PASSED	Year Grad.	Per Cent
Yale University School of Medicine		(1938)	89.5
Northwestern University Medical School (1940) 90.1, 90.4		(1939)	90.5, 91.6,
Rush Medical College		(1938) 88, (1939)	86.3, 90.4
The School of Medicine of the Division of the Biological Sciences		(1937) 87.2, (1938)	92
University of Illinois College of Medicine		(1939)	91.3
State University of Iowa College of Medicine (1937) 88, (1939)			84.3
University of Kansas School of Medicine		(1939)	89.2
Tulane University of Louisiana School of Medicine		(1935)	83.4
Johns Hopkins University School of Medicine		(1939)	83
Harvard Medical School		(1937)	85.5
Tufts College Medical School		(1936)	84.4
University of Michigan Medical School		(1939)	88.6
University of Minnesota Medical School 86,* 87.3,* 88, 90,* (1940) 79.5,* 82.3,* 84.1, 84.5, 85.3,* 85.3, 85.6,* 86.4, 86.6, 87.6,* 88.1,* 88.5,* 89.4			84.1,
Creighton University School of Medicine (1938) 80.1, (1940)			84.1
University of Nebraska College of Medicine (1939) 86, 86.1,			87.2
Columbia University College of Physicians and Surgeons (1937)			85.2
University of Oregon Medical School		(1939)	84.6
Jefferson Medical College of Philadelphia		(1937)	88.5
University of Toronto Faculty of Medicine		(1938)	86.1
University of Western Ontario Medical School		(1939)	86.3
McGill University Faculty of Medicine		(1937)	85.2

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Northwestern University Medical School		(1939)	Wisconsin
Rush Medical College		(1929)	Montana
University of Louisville School of Medicine		(1936)	Utah
University of Michigan Medical School		(1937)	Michigan
Univ. of Nebraska College of Med. (1934), (1936), (1938)			Nebraska
Western Reserve University School of Medicine		(1935)	Ohio
University of Oklahoma School of Medicine		(1937)	Oklahoma
Temple University School of Medicine		(1934)	Penna.
Univ. of Wisconsin Medical School (1929) Nebraska, (1936)			Wisconsin

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
Rush Medical College		(1939)	N. B. M. Ex.
Johns Hopkins University School of Medicine		(1921)	N. B. M. Ex.

* This applicant has received the M.B. degree and will receive the M.D. degree on completion of internship.

Pennsylvania Reciprocity Report

Mrs. Marguerite G. Steiner, acting secretary, Pennsylvania State Board of Medical Education and Licensure, reports 14 physicians licensed to practice medicine by reciprocity and 8 physicians so licensed by endorsement from October 9 through December 18. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
University of California Medical School		(1926)	R. Island
Yale University School of Medicine		(1926)	New York
Rush Medical College		(1936)	Minnesota
Johns Hopkins University School of Medicine (1934) Minnesota		(1924)	Connecticut,
University of Maryland School of Medicine and College of Physicians and Surgeons		(1937)	Maryland
Wayne University College of Medicine		(1937)	Michigan
University of Minnesota Medical School		(1933)	California
Hahnemann Medical College and Hospital of Philadelphia		(1938)	Mass.
Jefferson Medical College of Philadelphia		(1925)	New Jersey
Temple University School of Medicine		(1938)	New Jersey
University of Pennsylvania School of Medicine		(1935)	California
University of Tennessee College of Medicine		(1932)	Tennessee
Vanderbilt University School of Medicine		(1929)	Tennessee

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
Yale University School of Medicine		(1936)	N. B. M. Ex.
University of Louisville School of Medicine		(1939)	N. B. M. Ex.
Johns Hopkins University School of Medicine		(1939)	N. B. M. Ex.
Harvard Medical School		(1939)	N. B. M. Ex.
Long Island College of Medicine		(1938)	N. B. M. Ex.
Duke University School of Medicine		(1939)	N. B. M. Ex.
University of Pennsylvania School of Medicine		(1938)	N. B. M. Ex.
Woman's Medical College of Pennsylvania		(1939)	N. B. M. Ex.

Alabama Reciprocity Report

Dr. J. N. Baker, secretary, Alabama State Board of Medical Examiners, reports 11 physicians licensed to practice medicine by reciprocity and 1 physician so licensed by endorsement from Sept. 28 through Dec. 31, 1940. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Howard University College of Medicine		(1925)	Penna.
Tulane University of Louisiana School of Medicine (1939, 4) Louisiana		(1934)	Minnesota,
Johns Hopkins University School of Medicine		(1938)	Maryland
Univ. of Rochester School of Medicine and Dentistry		(1934)	Minnesota
Jefferson Medical College of Philadelphia		(1935)	Penna.
Meharry Medical College		(1929)	Georgia
University of Tennessee College of Medicine		(1931)	Tennessee

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
New York Medical College, Flower and Fifth Avenue Hospitals		(1938)	N. B. M. Ex.

Mississippi December Report

Dr. R. N. Whitfield, assistant secretary, Mississippi State Board of Health, reports 6 physicians licensed to practice medicine by reciprocity and 2 physicians so licensed by endorsement on December 13. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
University of Louisville School of Medicine		(1937)	W. Virginia
Medical Department of Tulane University of Louisiana		(1910)	Louisiana
University of Tennessee College of Medicine (1937), (1938) Tennessee		(1930), (1932),	

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
University of Minnesota Medical School		(1930)	N. B. M. Ex.
Duke University School of Medicine		(1935)	N. B. M. Ex.

Oregon October Report

Miss Lorienne M. Conlee, executive secretary, Oregon State Board of Medical Examiners, reports 5 physicians licensed to practice medicine by reciprocity on October 12. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Northwestern University Medical School		(1938)	Illinois
Rush Medical College		(1934)	Illinois
University of Illinois College of Medicine		(1928)	California
University of Nebraska College of Medicine		(1932)	Nebraska
University of Oregon Medical School		(1938)	California

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Privileged Communications: Privilege Applicable to Legislative as Well as Judicial Proceedings.—The City Council of the City of New York appointed a committee to inquire into charges of negligence and malpractice in the treatment of patients at a certain city hospital. Subpoenas duces tecum were served on the commissioner of hospitals of New York City and on the medical superintendent of the hospital involved, each of whom appeared before the committee but refused to "produce any papers or documents relating to complaints made by any one with respect to any of the internes, clinic physicians or visiting staff . . . or with respect to medical or other treatment or service furnished in the wards or clinics of the hospital containing data relating to the condition of the patients or to the medical or other treatment or service furnished to them." They based their refusal on section 352 of the Civil Practice Act of New York, which provides, in part, as follows:

> "a person duly authorized to practice physic or surgery, or a professional or registered nurse, shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity."

The sole question to be determined concerned the right of the defendants, by virtue of the privileged communications statute quoted, to refuse to produce the hospital records. The supreme court of New York, special term, New York County, held that the privilege applied only to judicial proceedings and directed the defendants to produce the records subpoenaed (20 N. Y. S. 712, abstr. J. A. M. A. 115:1661 [Nov. 9] 1940). That order on appeal to the supreme court of New York, appellate division, first department, was affirmed. The defendants thereupon appealed to the Court of Appeals of New York.

The plaintiff contended that the privileged communications statute, section 352 just quoted, since it is a part of the Civil Practice Act, governs only proceedings brought in a court of record, i. e. judicial proceedings, and is not available to prevent the examination of hospital records in legislative proceedings or inquiries. The Court of Appeals admitted that section 352 is contained in article 33 of the Civil Practice Act entitled "Evidence" and that the term evidence is ordinarily applied to proof received in judicial proceedings, but it pointed out that it was required to give the act a "broad and liberal construction, to carry out its policy." Section 354 of the same act provides that section 352 shall apply to "any examination of a person as a witness unless the provisions thereof are expressly waived upon the trial or examination by the . . . patient. . . ." Furthermore, continued the court, the rules governing the issuance and effect of subpoenas by legislative and judicial bodies are embodied in sections 403 to 408 of the Civil Practice Act, which sections are also a part of the same article 33 entitled "Evidence." To read into sections 352 and 354 a limitation which would render them inapplicable to proceedings brought pursuant to sections 403-408 of the same article would be neither justified by implication nor in conformity with a broad and liberal construction of the act. In the judgment of the court, therefore, since the legislature had not seen fit to limit the application of the privilege it had created, a physician who is called as a witness under the "Evidence" article of the Civil Practice Act may also claim the protection provided in the privileged communications statute contained therein, even though he is acting as a witness before a legislative committee rather than before a judge or jury. Accordingly, the Court of Appeals concluded that the defendants, the commissioner of hospitals of New York City and the medical superintendent of the hospital in question, should not be required to produce the records subpoenaed and so it reversed the order of the lower court.—*New York City Council v. Goldwater et al.; In re Lincoln Hospital, Bronx, 31 N. E. (2d) 31 (New York, 1940).*

Society Proceedings

COMING MEETINGS

Alabama, Medical Association of the State of, Mobile, Apr. 15-17. Dr. D. L. Cannon, 519 Dexter Ave., Montgomery, Secretary.

American Association for the Study of Neoplastic Diseases, Washington, D. C., Apr. 3-5. Dr. Eugene R. Whitmore, 2139 Wyoming Ave., N.W., Washington, D. C., Secretary.

American Association of Anatomists, Chicago, Apr. 9-11. Dr. E. R. Clark, Dept. of Anatomy, University of Pennsylvania School of Medicine, Philadelphia, Secretary.

American Association of Pathologists and Bacteriologists, New York, Apr. 10-11. Dr. Howard T. Karsner, 2085 Adelbert Road, Cleveland, Secretary.

American Association of the History of Medicine, Atlantic City, N. J., May 4-6. Dr. Henry E. Sigerist, 1900 East Monument St., Baltimore, Secretary.

American College of Physicians, Boston, Apr. 21-25. Mr. E. R. Loveland, 4200 Pine St., Philadelphia, Executive Secretary.

American Dermatological Association, New Orleans, Apr. 7-11. Dr. Harry R. Foerster, 208 East Wisconsin Ave., Milwaukee, Secretary.

American Gastro-Enterological Association, Atlantic City, N. J., May 5-6. Dr. Thomas T. Mackie, 16 East 90th St., New York, Secretary.

American Physiological Society, Chicago, Apr. 16-19. Dr. Philip Bard, 710 North Washington St., Baltimore, Secretary.

American Society for Clinical Investigation, Atlantic City, N. J., May 5. Dr. Eugene M. Landis, University of Virginia Hospital, Charlottesville, Va., Secretary.

American Society for Experimental Pathology, Chicago, Apr. 15-18. Dr. Harry P. Smith, Dept. of Pathology, University of Iowa, Iowa City, Secretary.

American Society for Pharmacology and Experimental Therapeutics, Chicago, Apr. 15-19. Dr. G. Philip Grabfield, 319 Longwood Ave., Boston, Secretary.

American Society of Biological Chemists, Chicago, Apr. 15-19. Dr. C. G. King, Dept. of Chemistry, University of Pittsburgh, Pittsburgh, Secretary.

American Surgical Association, White Sulphur Springs, W. Va., Apr. 28-30. Dr. Charles G. Mixter, 319 Longwood Ave., Boston, Secretary.

Arizona State Medical Association, Phoenix, Apr. 16-19. Dr. W. Warner Watkins, 15 East Monroe St., Phoenix, Secretary.

Arkansas Medical Society, Little Rock, Apr. 14-16. Dr. William R. Brooksher, 602 Garrison Ave., Fort Smith, Secretary.

Association for the Study of Internal Secretions, Atlantic City, N. J., May 2-3. Dr. E. Kost Shelton, 921 Westwood Blvd., Los Angeles, Secretary.

Association of American Physicians, Atlantic City, N. J., May 6-7. Dr. Hugh J. Morgan, Vanderbilt University Hospital, Nashville, Tenn., Secretary.

California Medical Association, Del Monte, May 5-8. Dr. George H. Kress, 450 Sutter St., San Francisco, Secretary.

Federation of American Societies for Experimental Biology, Chicago, Apr. 15-19. Dr. D. R. Hooker, 19 West Chase St., Baltimore, Secretary.

Florida Medical Association, Jacksonville, Apr. 28-30. Dr. Shaler Richardson, P. O. Box 1018, Jacksonville, Secretary.

Georgia, Medical Association of, Macon, May 13-16. Dr. Edgar D. Shanks, 478 Peachtree St., N.E., Atlanta, Secretary.

Iowa State Medical Society, Davenport, May 14-16. Dr. R. L. Parker, 3510 Sixth Ave., Des Moines, Secretary.

Kansas Medical Society, Topeka, May 13-15. Mr. C. G. Munns, 112 West Sixth St., Topeka, Executive Secretary.

Louisiana State Medical Society, Shreveport, Apr. 21-23. Dr. P. T. Talbot, 1430 Tulane Ave., New Orleans, Secretary.

Maryland, Medical and Chirurgical Faculty of, Baltimore, Apr. 22-23. Dr. Richard T. Shackelford, 1211 Cathedral St., Baltimore, Secretary.

Mississippi State Medical Association, Biloxi, May 13-15. Dr. T. M. Dye, Box 295, Clarksdale, Secretary.

Missouri State Medical Association, St. Louis, Apr. 28-30. Mr. E. H. Bartelsmeyer, 634 North Grand Blvd., St. Louis, Executive Secretary.

National Gastroenterological Association, New York, May 13-16. Dr. G. Randolph Manning, Room 319, 1819 Broadway, New York, Secretary.

National Tuberculosis Association, San Antonio, Tex., May 5-8. Dr. Charles J. Hatfield, 1790 Broadway, New York, Secretary.

Nebraska State Medical Association, Lincoln, May 5-8. Dr. R. B. Adams, 416 Federal Securities Bldg., Lincoln Secretary.

New Hampshire Medical Society, Manchester, May 13-14. Dr. Carleton R. Metcalf, 5 South State St., Concord, Secretary.

New York, Medical Society of the State of, Buffalo, Apr. 28-May 1. Dr. Peter Irving, 292 Madison Ave., New York, Secretary.

Northern Tri-State Medical Association, Tiffin, Ohio, Apr. 8. Dr. E. Benjamin Gillette, 320 Michigan St., Toledo, Ohio, Secretary.

Post Graduate Institute of the Philadelphia County Medical Society, Philadelphia, Mar. 31-Apr. 4. Dr. Rufus S. Reeves, 301 South 21st St., Philadelphia, Director.

Society for the Study of Asthma and Allied Conditions, Atlantic City, N. J., May 3. Dr. W. C. Spain, 116 East 53d St., New York, Secretary.

South Carolina Medical Association, Greenville, Apr. 15-17. Dr. Julian P. Price, 105 West Cheves St., Florence, Secretary.

Tennessee State Medical Association, Nashville, Apr. 8-10. Dr. H. H. Shoulders, 706 Church St., Nashville, Secretary.

Texas, State Medical Association of, Fort Worth, May 12-15. Dr. Holman Taylor, 1404 West El Paso St., Fort Worth, Secretary.

West Virginia State Medical Association, Charleston, May 12-14. Mr. Joe W. Savage, Public Library Bldg., Charleston, Executive Secretary.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1931 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

American Journal of Physiology, Baltimore

131:545-820 (Jan.) 1941. Partial Index

Production of Shock by Prolonged Continuous Injection of Adrenalin in Unanesthetized Dogs. N. E. Freeman, H. Freedman and C. C. Miller, Philadelphia.—p. 545.
Mechanism of Production of Brain Damage During Insulin Shock. D. B. Tyler, Los Angeles.—p. 554.
Renal Response to Repeated Administration of Postpituitary Extract. H. Silvette, Charlottesville, Va.—p. 601.
Mechanics of Gastric Evacuation. J. M. Werle, D. A. Brody, E. W. Ligon Jr., M. R. Read and J. P. Quigley, Cleveland.—p. 606.
Recovery of Fatigued Muscle Following Intravenous Injection of Potassium Chloride. H. E. Hoff, A. W. Winkler and P. K. Smith, New Haven, Conn.—p. 615.
Gaseous Nitrogen and Helium Elimination from Body During Rest and Exercise. A. R. Behnke and T. L. Willmon, Washington, D. C.—p. 619.
Cutaneous Diffusion of Helium in Relation to Peripheral Blood Flow and Absorption of Atmospheric Nitrogen Through Skin. A. R. Behnke and T. L. Willmon, Washington, D. C.—p. 627.
Nitrogen Elimination and Oxygen Absorption at High Barometric Pressures. T. L. Willmon and A. R. Behnke, Washington, D. C.—p. 633.
Influence of Right and Left Ventricles on Electrocardiogram. H. E. Hoff, L. H. Nahum and B. Kisch, New Haven, Conn.—p. 687.
Significance of Displacement of RS-T Segment. L. H. Nahum, H. E. Hoff and B. Kisch, New Haven, Conn.—p. 693.
Factors Determining Direction of T Wave: Effect of Heat and Cold on Dextrocardiogram and Levocardiogram. H. E. Hoff and L. H. Nahum, New Haven, Conn.—p. 700.
Effect of Desiccated Hog Bile and Hog Bile Acid Preparations on Volume and Constituents of Bile. A. L. Berman, E. Snapp, A. C. Ivy, V. H. Hough and A. J. Atkinson, Chicago.—p. 752.
Comparison of Histamine Content of Blood and Bone Marrow. C. F. Code and J. L. Jensen, Minneapolis.—p. 768.

Annals of Internal Medicine, Lancaster, Pa.

14:953-1122 (Dec.) 1940

*Hemolytic Jaundice: Clinical Analysis of Twenty-Eight Cases. J. C. Sharpe, Omaha.—p. 953.
Study of Syphilis of Aorta and Aortic Valve Area. C. F. Nichols, Philadelphia.—p. 960.
Chronic Dissecting Aneurysm of Aorta, Simulating Syphilitic Cardiovascular Disease: Notes on Associated Aortic Murmurs. B. A. Gouley and E. Anderson, Philadelphia.—p. 978.
Valuable Sign in Diagnosis of Functional Aortic Insufficiency. S. A. Loewenberg, Philadelphia.—p. 991.
*Formol Gel Reaction in Blood of Patients with Chronic Rheumatoid Diseases. C. W. Scull and R. Pemberton, Philadelphia.—p. 993.
Observations on Susceptibility of Pneumococci to Sulfapyridine, Sulfathiazole and Sulfamethylthiazole. F. C. Lowell, E. Strauss and M. Finland, Boston.—p. 1001.
Sulfathiazole in Treatment of Pneumococcic Pneumonia. V. B. Callomon and W. E. Goodpastor, Pittsburgh.—p. 1024.
Sulfapyridine Therapy in Pneumonia: Discussion of Apparent Failures and Complications. F. E. Smith Jr., R. Riley and O. R. Jones, New York.—p. 1032.
*The Problem of Pneumonia, with Reference to Chemotherapy and Serotherapy. P. H. Long and J. W. Haviland, Baltimore.—p. 1042.
Early Signs of Orthopedic Conditions. J. J. Nutt, New York.—p. 1050.
Social Components in Medicine. E. L. Bortz, Philadelphia.—p. 1065.

Hemolytic Jaundice.—Sharpe prefers the term chronic familial hemolytic jaundice to hemolytic jaundice, hemolytic anemia, acholuric icterus, acholuric ictero-anemia, hemolytic splenomegaly, splenic anemia or chronic infectious anemia with splenomegaly. He defines chronic familial hemolytic jaundice as a chronic microspherocytic anemia characterized by increased erythrocyte fragility, reticulocytosis, acholuric icterus and splenomegaly. Of his 28 patients 11 were male and 17 female; their ages varied from 3 to 63 years. The symptoms usually appeared within the first two decades of life. Occasionally, subclinical evidence of the disease would remain latent and unsuspected for many years and be discovered only when some other member of the family was found to have the disease in an active form. The 28 cases occurred in twelve families. The etiology of the disease remains obscure. The patient obtains a symptomatic "cure" following removal of the overactive spleen, even though telltale hematologic signs persist. Undue fatigue was usually the first and most common complaint. Dyspnea, palpitation and dizziness were often intermittently present but depended on the severity of the anemia. Splenomegaly was present in all but 2 latent cases. The size of the spleen varied at different times in the same patient and bore no relation to the severity of the disease. During the course of the disease, various complications developed that often completely altered its clinical picture. The complications were chiefly of two types: acute episodes of blood destruction and the formation of gallstones. Acute hemoclastic crises occurred at irregular intervals and were characterized by a sudden onset of pain in the upper part of the abdomen, nausea, vomiting and fever, accompanied by extreme weakness with an intensification of jaundice and pallor, an increasing enlargement of the spleen and a sharp drop in the blood count. Such crises have not occurred after splenectomy. Pigment cholelithiasis probably develops as a result of the persistent increased bilirubin content of the blood producing an increased load on the excretory function of the liver and gallbladder. Of 13 splenectomized patients only 3 have had to have their gallbladders removed. Pregnancy occurred nineteen times in 7 patients, and in 52 per cent of these instances it had some deleterious effect on the course of the disease. Not only was the anemia made more pronounced, but miscarriages and premature deliveries were more frequent. Mussey and Blakley have shown no gross alteration in the course of pregnancy, confinement or puerperium of 23 splenectomized women. Among the 13 splenectomized patients, adhesions about the spleen were relatively infrequent. Neither transfusions nor antianemic therapy was necessary before or after surgery in typical cases. There were no postoperative complications or fatalities. The convalescence was surprisingly rapid, and jaundice disappeared within a few days. The reticulocytes returned to normal numbers within the week. Iron and liver therapy have been of no value in improving the anemia or in preventing complications. The patients who have elected such conservative treatment continue to be subject to chronic invalidism and to the risk and uncertainty of acute exacerbations of the disease. It is the author's practice to recommend splenectomy for persons with active clinical manifestations irrespective of complications, age, or severity of the disease. The chronicity of symptoms and the uncertainty of serious complications more than offset the slight risk of operation, especially in view of the good health which the latter offers the patient.

Formol Gel Reaction in Chronic Rheumatoid Diseases.—Scull and Pemberton determined the formol gel reaction of 128 patients with severe and moderate atrophic, hypertrophic or mixed types of rheumatoid disease. They observed marked and early gelation, particularly among patients with active and severe atrophic arthritis, including spondylitis. Mild and late or delayed appearance of positive gelation was seen in the blood fluids of patients with mild atrophic and hypertrophic arthritis. Negative reactions were seen in arrested cases of both varieties as well as among a few normal control subjects. This indicates that the reaction is a reasonable suitable index of the extent of the systemic activity of the disease process. While less exact as a quantitative measurement than certain other measures, the authors point out that the test is simple and yet sensitive enough to be employed as a routine procedure. There is a significant degree of association of the formol gel reaction with the suspension stability of the erythrocytes. If the reaction is negative in the plasma, the sedimentation rate of the erythrocytes may reasonably be presumed to be within normal limits. Blood with positive reactions in the plasma generally shows decreased suspension stability. Positive gelation tends to occur with increased levels of globulin and with decreased levels of hemoglobin, though the latter is not high.

Chemotherapy and Serotherapy for Pneumonia.—According to Long and Haviland, over a period of two years the case fatality rate of pneumococcic pneumonia among adults has been reduced by two thirds at the Johns Hopkins Hospital.

It seems to have been stabilized at between 7 and 8 per cent. Their experience with sulfathiazole leads them to believe that it is as effective as sulfapyridine. One definite advantage of sulfathiazole is that it produces less nausea and vomiting in adults than does sulfapyridine. While sulfathiazole seems to produce more instances of drug fever and rash, it rarely causes anemia or granulocytopenia, and the authors have not yet encountered patients in whom acute agranulocytosis developed in the course of its use. They are of the opinion that the importance of early treatment of pneumonia by chemotherapeutic agents has not been sufficiently stressed and that every effort should be made to use either sulfathiazole or sulfapyridine as early as is possible in the course of pneumococcic pneumonia. They feel that every patient who is severely ill with pneumonia should receive combined type specific antipneumococcus serum and chemotherapy. The administration of the serum should be controlled by the Francis cutaneous test. If this is not possible, an initial dose of 200,000 units of type specific serum should be given intravenously after it has been determined that the patient is not sensitive to the particular serum to be employed. One hundred thousand units of serum should be administered every eight hours until crisis occurs. The authors' experience leads them to believe that from 10 to 15 per cent of patients require combined serotherapy and chemotherapy. Fewer patients may need the combined treatment if in the future specific treatment is started earlier.

Canadian Public Health Journal, Toronto

31:579-632 (Dec.) 1940

Tuberculosis and the Student Nurse. R. J. Collins and C. W. MacMillan, Fredericton, N. B.—p. 579.

Some Observations on Canadian Nutrition. E. W. McHenry, Toronto.—p. 584.

Developments in Public Health in Montreal During the Past Three Years. A. Groulx, Montreal.—p. 589.

Highlights on Hospitalization in Ontario. A. H. Sellers, Toronto.—p. 595.

Laboratory Procedures in Staphylococcic Food Poisoning. R. J. Wilson, Toronto.—p. 607.

Noise and Vibration Control. G. H. Ferguson, Ottawa, Ont.—p. 613.

Journal of Immunology, Baltimore

39:441-564 (Dec.) 1940

Nonspecific Factors in Resistance: V. Carbon Dioxide Tolerance. A. Locke, Pittsburgh.—p. 441.

Failure of Histaminase to Protect Guinea Pigs Against Histamine and Anaphylactic Shock. H. L. Alexander and D. Bottom, St. Louis.—p. 457.

Influence of Electrolytes on Cutaneous Reactivity of Seitz-Filtered Ragweed Solutions. C. A. Koch, A. R. Zoss and R. S. Hirose, Cincinnati.—p. 461.

Separation of Phase I Agglutinogen of Haemophilus Pertussis from Toxic Components. E. W. Flosdorf and Anne C. Kimball, Philadelphia.—p. 475.

Antigenic Structure of Hemolytic Streptococci of Lancefield Group A: VI. Immunologic Behavior of Nucleoproteins Extracted at Neutrality. S. Mudd and D. B. Lackman, Philadelphia.—p. 495.

Mechanical Properties of Thin Films of Serologically Active Substances Prepared from Group A Hemolytic Streptococci. J. B. Bateman, L. A. Chambers and H. E. Calkins, Philadelphia.—p. 511.

Passive Sensitization of Rabbit's Blood. C. A. Dragstedt, M. Ramirez de Arellano, A. H. Lawton and G. P. Youmans, Chicago.—p. 537.

Organ Specificity of Brain Broth as Shown by Passive Anaphylaxis in Guinea Pigs. G. H. Bailey and R. E. Gardner, Baltimore.—p. 543.

Journal Industrial Hygiene & Toxicology, Baltimore

22:427-496 (Dec.) 1940

Administration of Pure Oxygen to Compressed Air Workers During Decompression: Prevention of Occurrence of Severe Compressed Air Illness. R. R. Jones, J. W. Crosson, F. E. Griffith, R. R. Sayers, H. H. Schrenk, Washington, D. C., and E. Levy, New York.—p. 427.

Studies on Lead Hazards in Certain Phases of Printing: I. Actual Lead Exposures as Measured by Amount of Lead in Printing Atmospheres: II. Actual Lead Absorption as Measured by Physical Examinations, Blood and Urine Studies. H. W. Ruf and E. L. Belknap, Milwaukee.—p. 445.

Dust Counting: Simplified Technic. H. R. Ohlheiser and L. B. Lawrence, South Bend, Ind.—p. 472.

Acute Response of Guinea Pigs and Rats to Inhalation of Vapors of Isophorone. H. F. Smyth Jr. and Jane Seaton, Pittsburgh.—p. 477.

Toxic Effects on Rats and Rabbits of N, N-Amyl-Benzyl-Cyclohexylamine. W. Deichmann and K. V. Kitzmiller, Cincinnati.—p. 484.

Toxic Effects on Rabbits and Rats of Lauryl-Diethylene-Triamine. W. Deichmann, K. V. Kitzmiller and F. Spiegel, Cincinnati.—p. 488.

Journal of Urology, Baltimore

44:727-884 (Dec.) 1940. Partial Index

Urinary Excretion of Androgens by Patients with Benign Hypertrophy of Prostate. R. A. Moore, St. Louis; Mary L. Miller and A. McLellan, New York.—p. 727.

End Results of Injection Treatment of Hydrocele. G. H. Ewell, Madison, Wis.; C. R. Marquardt and J. C. Sargent, Milwaukee.—p. 741.

Treatment of Gonorrheal Urethritis in the Male with Sulfathiazole: Analysis of Fifty-Five Cases. F. Knight, C. A. W. Uhle and L. W. LaTowsky, Philadelphia.—p. 748.

Squamous Cell Changes and Infection in Urinary Tract. A. J. Scholl, Los Angeles.—p. 759.

Injury of Ureter Due to Cystoscopic Intra-Ureteral Instrumentation: Report of Sixteen Cases. C. F. Rusche and S. K. Bacon, Los Angeles.—p. 777.

End Results of Uretero-Intestinal Implantation. A. B. Hepler, Seattle.—p. 794.

Hematuria Associated with Dissecting Aneurysms of Abdominal Aorta. T. I. Buckley, Oakland, Calif.—p. 816.

Incontinence of Urine in Women. F. Farman, Los Angeles.—p. 841.

Treatment of Certain Types of Bladder Tumor by Contact X-Ray Therapy (Chaoul Technic). L. S. Goin, E. F. Hoffman and J. J. Crane, Los Angeles.—p. 847.

Renal Rickets. D. A. Charnock, Los Angeles.—p. 850.

Tuberculin Skin Test in Guinea Pigs Injected with Suspected Urine Sediment. J. C. Negley, Glendale, Calif., and E. Bogen, Olive View, Calif.—p. 860.

Renal Tuberculosis. P. A. Rohrer, Seattle.—p. 871.

Laryngoscope, St. Louis

50:1107-1184 (Dec.) 1940

Abstracts from Literature Relating to Conditions in Trachea and Bronchi. C. J. Imperatori, N. Y.—p. 1107.

Review of Reconstructive Surgery of Face. F. McDowell and J. B. Brown, St. Louis.—p. 1117.

Late Complications of Brain Abscess. I. Cohen, New York.—p. 1139.

Management of Brain Abscess of Otorhinogenic Origin. J. E. J. King, New York.—p. 1146.

Brain Abscess. A. Kaplan, New York.—p. 1159.

Use of Colloidal Thorium Dioxide in Roentgenography of Paranasal Sinuses. R. C. Grove, New York.—p. 1165.

Cerebrospinal Rhinorrhea Pathologic Findings. M. L. Som and R. Kramer, New York.—p. 1167.

Esophageal Foreign Body with Complications: Two Cases. F. Vistreich, New York.—p. 1178.

Medical Annals of District of Columbia, Washington

9:413-460 (Dec.) 1940

Renal Involvement in Hypertensive Vascular Disease. E. Weiss, Philadelphia.—p. 413.

Recognition and Treatment of Various Forms of Pericarditis. W. A. Bloedorn, Washington.—p. 422.

Vitamin C: Review of Our Present Knowledge. R. J. Kassan and J. H. Roe, Washington.—p. 426.

Significance of Bleeding from Urinary Tract. W. C. Stirling, Washington.—p. 434.

Mycotic Arteriovenous Fistula: Report of Case. W. M. Yater, W. F. Luckett and B. W. Leonard, Washington.—p. 439.

Nebraska State Medical Journal, Lincoln

26:1-36 (Jan.) 1941

*Therapeutic Value and Limitations of Vitamin K. A. J. Quick, Milwaukee.—p. 1.

*Management of Common Duct Lesions. R. R. Best, Omaha.—p. 5.

Rupture of Quadriceps Femoris Tendon. J. W. Martin, Omaha.—p. 11.

Bronchogenic Carcinoma Successfully Treated by Total Pneumonectomy: Case. J. D. Bisgard, Omaha.—p. 13.

Carcinoma of Rectum. C. W. McLaughlin Jr. and W. M. Dilworth, Omaha.—p. 16.

Treatment of Intractable Pain: Report of Eleven Cases. R. A. Youngman, Falls City.—p. 22.

Therapeutic Value and Limitations of Vitamin K.—Quick lists three important ways in which a serious depletion of prothrombin (prothrombinopenia) can occur; inadequate intake of vitamin K, faulty absorption due to lack of bile salts in the intestine, and impaired hepatic function resulting in a decrease of prothrombin synthesis. Because hypoprothrombinemia is a common (or even normal) physiologic condition of the newborn, bleeding is exceedingly dangerous. Since this hypoprothrombinemia responds quickly and effectively to vitamin K it is the duty of every physician to prescribe the vitamin immediately if signs of bleeding, even insignificant ones, appear. Also in the case of any difficult delivery in which the baby may have sustained cranial injury the prompt oral administration of vitamin K is indicated. Vitamin K must be part of the preoperative treatment of newborn infants and it should also be supplied during convalescence.

Inadequate absorption of vitamin K occurs most frequently in obstructive jaundice. Only a quantitative determination of prothrombin alone can establish its level. In uncomplicated cases without hepatic injury the response to vitamin K is at times spectacular. Every jaundiced patient is apt to have a low prothrombin level and operation should be postponed until the prothrombin is raised to at least from 60 to 70 per cent of normal. Even then the prothrombin may drop precipitously soon after operation, but with adequate preoperative treatment this is rarely serious. It is best to give vitamin K postoperatively, especially if the prothrombin remains persistently low, but unless bile salts are given concomitantly little vitamin K is absorbed and no benefit is derived. When striking impairment of hepatic function exists, operation, unless absolutely necessary, should not be done until the hepatic efficiency is improved. High carbohydrate diet, intravenous dextrose, calcium salts and gelatin feeding are helpful measures. When bleeding is encountered and the prothrombin is not elevated by vitamin K and bile salts, fresh blood transfusion is necessary. Prothrombin deteriorates in stored blood. Restoration of hepatic efficiency is of paramount importance, for without its proper function all treatment with vitamin K is in vain. Vitamin K is effective only when hypoprothrombinemia can be demonstrated. Since the prothrombin is normal in hemophilia, the purpuras and a variety of other hemorrhagic diseases no benefit can be expected from its use for these conditions.

Common Duct Lesions.—Best points out that whether the common bile duct lesion is associated with jaundice or a fistula the preoperative management is the same, as the danger is failure of bile to reach the intestine resulting in prothrombin deficiency and a hemorrhagic tendency. Hepatic function must be evaluated. If found much below normal, a vigorous effort should be made to increase it before intervention is attempted. A hippuric acid test below 2.6 Gm. indicates hepatic deficiency, and one below 1.5 Gm. suggests a rather poor prognosis. Even if the function is good, every patient with jaundice or a suspected common duct lesion should have the advantage of all available measures for building up hepatic function and reserve. Any bleeding tendency should be controlled. For the last five years the author has used viosterol and bile salts in the majority of his cases, and vitamin K in comparatively few cases. Now since vitamin K is not distasteful and is easily administered, he uses it. The mechanism of the former medication is some synthesis of either viosterol or the vitamin K into the complex protein prothrombin, rather than the replacement of a vitamin. Bile is necessary for the intestinal absorption of these substances. In addition to the specific therapy, blood transfusion continues to be a valuable supplement. When a common duct lesion is known or suspected, the gallbladder should not be removed until the patency of the common duct has been ascertained, as the gallbladder may be utilized for a biliary-gastrointestinal anastomosis. Most strictures of the common duct require anastomosis of the remaining dilated portion to the duodenum or stomach. In most instances malignant lesions of the common duct are so advanced that only hepatic decompression or biliary-gastrointestinal anastomosis will relieve the jaundice. The malignant tumor which most often gives rise to jaundice is carcinoma of the pancreas compressing and obstructing that portion of the common duct which passes through or is adjacent to the head of the pancreas. Here the two stage procedure of Whipple offers some hope of a successful surgical attack. A biliary fistula should always be injected with an opaque medium and a cholangiogram made to ascertain whether a stone remains or a stricture is present, or whether merely spastic dyssynergia exists, not requiring a surgical intervention; if such is the case the condition is relieved by the biliary flush. If a biliary fistula exists and neither the cholangiogram nor the operative observations reveal any available duct tissue for anastomosis, the fistula may be dissected out as an intact tube and the end implanted into the stomach, duodenum or a loop of jejunum brought up anterior to the colon, for the biliary-intestinal anastomosis. The postoperative management of these patients is vitally important.

New England Journal of Medicine, Boston

224:1-44 (Jan. 2) 1941

Recollections and Letters of Sir James Mackenzie. J. H. Pratt, Boston.—p. 1.
Transurethral Electroresection as Opposed to Prostatectomy. G. G. Smith, Brookline, Mass.—p. 10.
Disorders of Nutritive Deficiency and Their Treatment. J. S. McLester, Birmingham, Ala.—p. 16.
Clinical Blood Chemistry in General Practice. W. T. Salter, Boston.—p. 19.

Public Health Reports, Washington, D. C.

55:2369-2412 (Dec. 27) 1940

Chest Fluoroscopy with Portable X-Ray Equipment on 35 Mm. Film. W. P. Dearing and A. E. Turner.—p. 2369.
Qualifications of Professional Public Health Personnel: II. Health Officers and Other Medical Personnel. M. Derryberry and G. Caswell.—p. 2377.
Disabling Morbidity Among Industrial Workers, Third Quarter of 1940, with Observations on Influenza, Bronchitis and Pneumonia, 1931-1940. W. M. Gafafer.—p. 2397.

56:1-40 (Jan. 3) 1941

Mental Hygiene in the State Health Department. V. H. Vogel.—p. 1.
Influence of Dietary Protein on Toxicity of Sulfanilamide. M. I. Smith, R. D. Lillie and E. F. Stohlman.—p. 24.

Radiology, Syracuse, N. Y.

35:651-782 (Dec.) 1940

*Solitary Myeloma of Bone: Review of Roentgenologic Features, with Report of Four Additional Cases. L. W. Paul and E. A. Pohle, Madison, Wis.—p. 651.
*Multiple Myeloma. L. C. Kinney, San Diego, Calif.—p. 667.
Intra-Orificial Roentgen Therapy: Improvements in Apparatus. W. W. Wasson, J. S. Bousloq and A. P. Jackson Jr., Denver.—p. 676.
*Value of Diagnostic Criteria for Choice of Therapeutic Procedure in Management of Acute Intestinal Obstruction: Experimental and Clinical Observations. O. H. Wangensteen, Minneapolis.—p. 680.
Grooved Defect of Humeral Head: Frequently Unrecognized Complication of Dislocations of Shoulder Joint. H. A. Hill and M. D. Sachs, San Francisco.—p. 690.
Roentgenographic Findings in Neurocutaneous Syndromes. G. W. Henblein, E. P. Pendergrass and B. P. Widmann, Philadelphia.—p. 701.
Thorium Dioxide as Aid in Differential Diagnosis of Pylephlebitis. H. Koster, Brooklyn.—p. 728.
Status of Some Technic Factors in Cholecystography. M. Feldman, Baltimore.—p. 735.

Solitary Myeloma of Bone.—Paul and Pohle arrive at the following conclusions after reviewing the 41 cases of single osseous myelomas reported in the literature and their 4 previously unpublished cases: 1. Solitary bone myeloma cannot be considered rare. 2. Pathologic reports indicate no essential difference between solitary and multiple forms of myeloma. The malignant degree of bone myeloma may vary with generalization occurring early in some (typical multiple myeloma) and late or never in others. 3. Roentgenologically there are two principal forms; in one the resemblance to giant cell tumor is striking, in the other osteolysis predominates but osseous expansion may be present. While roentgenologically it is not possible to predict the malignant degree of a myeloma, the trabeculated, multicystic type tends to run a more benign course. When generalization occurs, the type is usually typical multiple myeloma. 4. Because the tumor may be relatively benign, strenuous efforts to eradicate it are warranted. In the spine, laminectomy with removal of as much of the tumor as possible, followed by thorough irradiation, is the treatment of choice. In the pelvis and other surgically inaccessible bones external irradiation may arrest or possibly cure the disease. In the long bones, irradiation is advocated as the first measure. If this fails or the lesion recurs, local excision or amputation should be considered. 5. Solitary myeloma must be differentiated, roentgenologically, from giant cell tumor, localized fibrocystic disease, malignant metastasis, osteogenic sarcoma, Ewing's tumor and some rare bone tumors. The age incidence (generally from 29 to 65 years), location (often in the dorsal spine, pelvis, femur and humerus) of the lesion, symptomatology and roentgen appearance aid in differentiation. Thirty-nine of the patients were male and 10 female. Sixteen patients were between 50 and 60 years of age. At the present time roentgen examination alone may establish the probability

of its existence. In most instances final proof will depend on microscopic examination of tissue. Biopsy is indicated so that adequate treatment may be instituted.

Multiple Myeloma.—Kinney points out that multiple myelomas are malignant osteolytic tumors which arise from cells in the red bone marrow. They have no relation to osteogenetic cells and therefore do not produce bone. By the time the lesions are sufficiently large to be seen roentgenologically they are generally multiple. The four definite types of myeloma recognized by the Registry of the American College of Surgeons, depending on the predominant type of marrow cell found in the lesion, are the plasma cell, myelocyte, erythroblast and lymphocyte. As the disease progresses the lesions increase in size and number and the number of bones involved also increases. While there are no characteristic symptoms, the most usual is pain in the lumbar region or chest. The presenting symptoms may in no way point to the disease. They may be those of chronic sinusitis, gastric hemorrhage, acute pleurisy or herpes zoster, or they may be entirely absent. Multiple myeloma has been associated with the finding of Bence Jones protein in the urine, and this proteinuria has been thought characteristic of the disease. Bence Jones proteinuria occurs in from 50 to 65 per cent of cases of myeloma, but it is not pathognomonic. Its finding eliminates hyperthyroidism. Evidence of nephritis occurs in about 70 per cent of cases. The blood picture is not characteristic, although a progressive anemia is usually present. The bones most frequently involved are the spine, ribs, skull and pelvis. However, its absence from any one of these locations does not rule out myeloma. The most characteristic roentgen observations are small, multiple, clean-cut areas of osseous destruction having the appearance of being punched out of otherwise normal bone. In the skull the typical sharply circumscribed lesions are usually found in the frontal or upper parietal bones. In advanced lesions these areas may coalesce and give a diffuse mottling of the skull. In the spine the typical, small, discrete lesions may be seen in the bodies of one or more vertebrae, but there may be extensive destruction of the vertebral bodies by osteolytic lesions which presents no roentgen evidence until the cortex is involved. The usual signs are rarefaction, with fracture or collapse of one or more bodies. As the disease progresses there may be diffuse mottling and softening leading to marked swelling of the intervening disks. Usually the lesions in the spine are not characteristic and present no definite differentiation from other osteolytic conditions. In the ribs the most frequent finding is diffuse mottling and demineralization. Cyst-like areas of expansion with palpable tumors or complete destruction of portions of a rib may be present. Frequently multiple spontaneous fractures in several ribs occur. This is diagnostic of multiple myeloma. In the ends of the long bones the lesions may fuse into large cystlike areas which simulate localized cystic osteitis. Occasionally the lesions may simulate those of osteoclastic metastases, but the typical early lesions are small discrete areas of destruction in normal bone. Multiple myeloma does not metastasize to the lung fields. This is an important diagnostic feature. The author believes that the probability of multiple myeloma should be considered in any adult who has multiple osteolytic lesions or multiple spontaneous fractures. High serum calcium and secondary hyperplasia of the parathyroids in multiple myeloma are not accompanied by the low serum phosphorus and the low calcium balance typical of parathyroid disease. The reactions of osteitis and sclerosis frequently seen in and around metastatic lesions are never observed in myeloma. Multiple myeloma lesions are purely osteolytic, and osteoblastic changes are evidences of metastases. The lesions of myeloma are never accompanied by the thickening of the tables of the skull characteristic of Paget's disease.

Roentgen Identification of Intestinal Obstruction.—Wangensteen states that by proper coordination of clinical and roentgen data a large number of acute abdominal lesions may be identified correctly without operation. Roentgen studies are particularly helpful in determining the site of acute intestinal obstruction and its consequent treatment. Careful integration of clinical and roentgen data can determine that intestinal obstruction is present, whether it is simple or strangulating, its site and whether it is partial or complete. The nature of most obstructions can be identified correctly clinically, except enteric intussusceptions and gallstone obstruction. Clinical and roentgen evidence have made the early diagnosis of gallstone obstruction possible. Such a diagnosis of obstruction and the patient's status can aid in selecting proper therapeutic measures. Liberal administration of saline solution will correct the dechlorination and dehydration of high obstruction. This expedient does not influence the obstructing agency. Blood transfusion is an important item in all strangulating obstructions in which the blood loss may be serious. In high grade obstructions, blood or plasma transfusion and the dependent (Trendelenburg) posture may have a favorable influence on the blood pressure. In all high grade obstructions, inhalation of high concentrations of oxygen is a worth while auxiliary procedure. However, without concomitant suction applied to an indwelling duodenal tube, inhalations of oxygen are not effective. Decompression is the main agency in managing intestinal obstruction. Many simple mechanical obstructions of the small intestine can thus be treated successfully without operation. These constitute largely partial obstructions caused by adhesive kinks or bands. All strangulating obstructions and all obstructions of the colon with considerable distention should be operated on at once. These two types of obstruction contraindicate all attempts of conservative decompression. In determining whether a satisfactory decompression has been achieved by conservative means, repeated roentgen study is important. Relief of pain is not enough. Failure to decompress distended intestinal coils after a reasonable time with suction suggests the need of operative intervention. Most partial obstructions of a simple nature can be decompressed satisfactorily by the indwelling tube. High grade complete obstruction, if not decompressed within twenty-four to thirty-six hours, should be submitted to operation. Enterostomy is the safest procedure in such instances. During a period of seven years, when suction has played an important part in the management of intestinal obstruction, decompression by suction alone has been accomplished in 43.6 per cent of cases encountered at the University of Minnesota Hospital. The Miller-Abbott tube did not raise this percentage, but it did prove of value in the detection of occult lesions in the intestine, such as neoplastic strictures, which often fail to exhibit roentgen evidence of their presence. Such strictures often cause recurrent obstruction. This can be identified during an obstructive phase by the presence of visible and palpable peristalsis—which suggest hypertrophy of the muscle of the intestine wall.

Rhode Island Medical Journal, Providence

24:1-18 (Jan.) 1941

Obstructed Labor. G. W. Waterman, Providence.—p. 1.
Manual Removal of Placenta: Twelve Year Study. C. Potter, Providence.—p. 3.
Tragedies and Calamities of Surgery. A. W. Eckstein, Providence.—p. 6.
Local Refrigeration and Hibernation in Treatment of Cancer. F. E. Hanley, East Providence.—p. 12.

Southern Surgeon, Atlanta, Ga.

10:1-78 (Jan.) 1941

Ankylosis of Mandible. G. W. N. Eggers, Galveston, Texas.—p. 1.
Endometriosis as Cause of Intestinal Obstruction: Report of Two Cases. G. P. Grigsby, Louisville, Ky.—p. 8.
Fatal Infection of Abdominal Wall Following Appendectomy. R. J. White, Fort Worth, Texas.—p. 13.
Diagnosis and Treatment of Trigeminal Neuralgia, with Consideration of Total and Subtotal Section of Fifth Cranial Nerve. W. M. Craig, Rochester, Minn.—p. 17.
Perineal-Abdominal Operation for Cancer of Rectum. A. O. Singleton, Galveston, Texas.—p. 30.
Nonparasitic Cysts of Spleen: Report of Case. T. D. Watts and H. J. Warthen, Richmond, Va.—p. 34.
Direct X Irradiation of Tumors. J. D. Hancock and J. Love, Louisville, Ky.—p. 39.
Sterility Relieved by Left Salpingostomy Following Right Salpingo-Oophorectomy. W. T. Black Jr., Memphis, Tenn.—p. 42.
Ovarian Hemorrhage. H. J. Copeland and T. J. Floyd Jr., Griffin, Ga.—p. 44.
Brief History of Surgical Societies. M. W. Sherwood and T. Speed, Temple, Texas.—p. 50.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

Brain, London

63:205-294 (Sept.) 1940

*Analysis of 1,433 Cases of Paroxysmal Trigeminal Neuralgia (Trigeminal Tic) and End Results of Gasserian Alcohol Injection. W. Harris.—p. 209.
Optic Atrophy Associated with Pernicious Anemia. J. W. A. Turner.—p. 225.
Form of Familial Presenile Dementia with Spastic Paralysis. C. Worster-Drought, J. G. Greenfield and W. H. McMenemey.—p. 237.
Relation of Atrophy to Fibrillation in Denervated Muscle. D. Y. Solandt and J. W. Magladery.—p. 255.
Experimental Lesions in Basal Ganglions of Cat. E. G. T. Liddell and C. G. Phillips.—p. 264.
Familial Pes Cavus and Absent Tendon Jerks: Its Relationship with Friedreich's Disease and Peroneal Muscular Atrophy. J. D. Spillane.—p. 275.

Paroxysmal Trigeminal Neuralgia and Gasserian Alcohol Injection.—Harris has treated within thirty years about 2,500 persons with trigeminal tic (1,056 in private practice) by alcohol injection. He has notes on only 377 of the hospital patients. Of the total of 1,433 patients 943 were women and 490 were men. Notes on the ages of 1,119 patients show that pain in 897 began between the ages of 41 and 70. Peripheral sepsis, dental caries, pyorrhea, antral abscess and sinusitis are the prime cause of the disease. Letters were written to 765 private patients whose results from alcohol anesthesia were good. Of the 457 replies received, 316 reported that there had been no recurrence of pain for from three up to thirty-one years, usually with no alteration in the numbness; 212 of these patients were still alive and completely free of neuralgic tic at the time of the follow-up. Patches of shingles of herpes febrilis type were not an uncommon sequela of gasserian injection. This requires no treatment beyond some soothing ointment and leaves no scar or any subsequent neuralgia. The sense of taste was lost completely on the numbed half of the tongue and palate of 167 patients. Sometimes taste is recovered even though complete anesthesia remains. In some cases of total ganglion anesthesia the gustatory loss is permanent, in 1 case for more than twenty-four years. In 2 cases the loss of taste was complete over the back of the tongue, pharynx and palate, as well as on the front of the tongue. However, the actual gustatory fibers are not damaged. One of the most consistent results of total anesthesia resulting from gasserian destruction is complete loss of deep pressure sensibility. Sores around the nasal alae, especially just inside the nostril, and sometimes also on the cheek or forehead occur after a few gasserian injections. The risk of neuroparalytic keratitis complicating gasserian operation or injection is greatly diminished by the instillation of a drop of liquid petrolatum three or four times a day. Hyperesthesia to cold following gasserian injections, with resultant total anesthesia, is sufficiently frequent to prove reality. It may be due to a lowered threshold of sympathetic sensory conduction. In a small proportion of gasserian operations or injections, although the true tic may be entirely cured and the trigeminal anesthesia complete, a new type of pain may appear in from six weeks to three months. The term trigeminal causalgia may be justified by the frequent complaint of burning sensations in the face. Further gasserian injection or operation usually make the pain apparently worse. If the pain arises in the medullary nucleus, resection of the trigeminal fillet on the opposite side in the pons might give relief. This trigeminal causalgia seems to be identical with Frazier and Russell's atypical neuralgia, which may arise spontaneously in untreated cases.

Journal of Laryngology and Otology, London

55:449-472 (Oct.) 1940

Mechanism of Acusticolateral Sense Organs in Fishes, with Special Reference to Problems in Physiology of Semicircular Canals. A. Sand.—p. 449.
Multiple Complications Including Metastatic Lung Abscess Following Mastoid Infection. R. Smith.—p. 459.
Bilateral Lymphosarcoma of Tonsils. S. Young and L. W. Price.—p. 463.

Lancet, London

2:799-830 (Dec. 28) 1940

Pediatrics: Past, Present and Prospective. R. Hutchison.—p. 799.
*Outbreak of Sonne Dysentery. R. Cruickshank and R. Swyer.—p. 803.
Porphyrinuria in Case of Industrial Methyl Chloride Poisoning. J. N. M. Chalmers, A. E. Gillam and J. E. Keech.—p. 806.
*Phenothiazine as Anthelmintic in Threadworm and Roundworm Infections. P. Manson-Bahr.—p. 808.
Volvulus of Intestine with Intertwining Loops. M. Paul.—p. 809.

Outbreak of Sonne Dysentery.—The outbreak of dysentery described by Cruickshank and Swyer occurred in a school which was temporarily in use as a nursery for infants and young children. On Nov. 15, 1939, 19 were received at the authors' hospital, where they were subdivided into small groups and all patients were strictly barrier nursed with a view to eliminating cross infection from either the alimentary or the respiratory tract. Further cases were admitted up to December 2, making a total of 32 cases. The intestinal symptoms were not severe. The average number of stools was about three a day, and in no case was there evidence of dehydration. The commonest type of stool was green, loose and offensive and contained mucus. Because it has been suggested that gastroenteritis may be either a cause for or an effect of respiratory tract disease, attempts were made to ascertain whether any such association existed. Rhinitis was present on admission in 10 instances. In 3 of these cases there was some evidence of otitis media. Bronchitis was present in 5 cases, associated with chronic otitis media in 1 case and rhinitis in 1 case. Thus gastroenteritis of dysentery type seems in some degree to be a predisposing factor to secondary infections of the upper respiratory tract. It was arranged that a specimen of feces and a rectal swab should be obtained for bacteriologic examination from every patient twice weekly during the first two or three weeks and after that at weekly intervals until discharge. These investigations brought out the following points: 1. By repeated examination of both fecal specimen and rectal swab the Sonne bacillus can be isolated from most clinical cases. The rectal swab gives a much higher proportion of positive results than the fecal specimen. 2. The Sonne bacillus persists in the intestine in a gradually decreasing proportion of cases after subsidence of the acute infection. Thus the convalescent carrier is probably an important reservoir for the spread of infection, and at least three consecutive negative reports should be obtained before a patient is released from the hospital. 3. The Sonne bacillus is more persistent than other dysentery bacilli to external destructive agents, and many remain alive for days in fecal specimens if no preservative is added. 4. The fermentation of xylose by certain strains of the Sonne bacillus is closely correlated with epidemiologic data and may thus be helpful in tracing the source or mode of spread of an epidemic. 5. The Widal reaction has some diagnostic value in Sonne dysentery, but a proportion of cases fail to produce demonstrable agglutinin in the blood.

Phenothiazine as an Anthelmintic.—According to Manson-Bahr, phenothiazine, a thiazine dye, has been shown to be effective against culicine larvae, against strongyloid worms in sheep and against stomach worms in animals. It is excreted in the urine and acts as a urinary antiseptic. Three Indian lascars infected with Ancylostoma duodenale were given phenothiazine in doses ranging from 30 to 40 Gm. but the results suggest that the drug is ineffective for worms in the small intestine; similar results have been found in animals. Nine patients with Ascaris lumbricoides were treated; 5 had a double infection with roundworms and hookworms and 2 a double infection with roundworms and whipworms. These 7 patients were given total doses ranging from 16 to 48 Gm. Only one roundworm was recovered, and the whipworms were unaffected. Of the remaining 2 patients, 1 had a multiple infection with roundworms, hookworms, whipworms and threadworms, the other had roundworms only. They were given 8 Gm. daily for three days, followed by a dose of sodium sulfate, and results were more satisfactory, all the roundworms being removed. Phenothiazine has given good and permanent results in the treatment of threadworm infections, especially in children. Effects on 6 children and 3 adults are recorded; all were cured, though 3 (1 child and 2 adults) required a second course. The following doses are advised: 2 Gm. daily for seven days for children under 8, and half the dose for children under 4; 8 Gm. daily for at least five days for adults.

Wiener medizinische Wochenschrift, Vienna

90:821-836 (Oct. 26) 1940

Obliteration Therapy of Bartholinic Cysts. A. Botis.—p. 821.
Treatment of Dysentery. O. Haus.—p. 822.
Spina Bifida Occulta and Calculi in Urinary Passages. M. A. Sarpyener.—p. 823.
*Function of Parathyroids After Goiter Operations. S. von Posgay.—p. 825.

Parathyroid Function After Goiter Operations.—According to von Posgay, there exist two opposing views regarding the changes in the parathyroids following operations on the thyroid. Melchior, Nothmann, Mandl and others maintain that after operations on the thyroid, in contradistinction to other operations, there develops a tendency to tetany which becomes manifest through an increased electrical irritability of the nerves and through a reduced blood calcium. Löwenstein and Danheiser deny the existence of parathyroid lesions and reject the possibility of latent tetany. The author investigated this problem in 59 patients who had undergone goiter operations. He examined the calcium content of the blood and the electrical irritability of the nerves before and after the operation. His investigations revealed that latent tetany was not present. Except in cases of manifest tetany he was never able to demonstrate a change in the electrical irritability of the nerves. He confirms Löwenstein's opinion that if an increase in nervous irritability occurs it is due to the unavoidable toxic condition that develops after operation rather than to an injury of the parathyroids. He found that in some cases there may be a decrease in the calcium content, but the values never go below normal. Although these reductions constitute a partial corroboration of the views expressed by Melchior and Mandl, the author thinks that they do not justify the conclusion that an occasional reduction in the calcium content is a definite sign of inadequate functioning of the parathyroids. This assumption would be justified only if the reduction in the calcium content was accompanied by an increase in the electrical irritability of the nerves and if, at least in some of the cases, the clinical signs of tetany would appear. The author concludes that the occasional fluctuations in the calcium content are the results of the sudden disturbance in the endocrine system, which in turn is caused by strumectomy or by other operations. The author cites reports from the literature describing tetany following operations in which injury of the parathyroids was impossible such as operations for duodenal ulcer or hernia.

Mitt. a. d. med. Akad. zu Kioto, Kyoto

20:299-680 (Oct.) 1940. **Partial Index**

*Rapid Agglutination Test for Typhoid and Paratyphoid Fever. K. Nakamura.—p. 299.
*Clinical Observations on Transfusion of Incompatible Blood. Y. Tominaga.—p. 337.

Rapid Agglutination Test for Typhoid and Paratyphoid Fever.—Confronted with a need for a rapid and simple method of a diagnostic test for typhoid and paratyphoid fever in a field hospital, Nakamura devised the following test: A 20 hour growth culture each of Eberthella and Salmonella on agar slant is suspended in 3 cc. of antiformin (containing from 0.5 to 1 per cent of sodium chloride) in sterile salt solution. After careful neutralization of the suspension with acetic acid, a few drops of sterile solution of Löffler's methylene blue are added and preserved with 5 per cent phenol. A drop of capillary blood is received on a small watch glass and at once diluted and mixed with 4 drops of 3.5 per cent solution of sodium chloride. One drop of this 1:5 dilution of blood is then introduced into the hollow of each of three hanging drop slides, one slide for each of the three strains of organisms to be tested; 1 drop of the test fluid is then added to each, and the contents of each slide are at once thoroughly mixed by rotating the slide for a few seconds. The extent of clumping is observed in the course of a few minutes (from five to thirty), the strongly positive reactions being visible to the naked eye at the end of five minutes and the weakly positive ones in about thirty minutes. A magnifying glass or low power microscope may aid visualization in the weak reactions. The red blood cells in the test mixture usually settle toward the central portion of the hollow in the slide, and the agglutination, which is either bluish or sometimes greenish blue, may be clearly seen at the periphery of the mixture. This test can also be performed with a slightly lower dilution (1:2) of blood. In comparing the results of this test with those obtained by the Widal reaction in 100 cases of typhoid, Nakamura's method gave 98 per cent positive while the Widal test yielded 95 per cent, thus closely paralleling each other. The earliest positive reaction was obtained on the fifth or sixth day of infection. The author tested the blood of 30 persons who had previously been vaccinated against these organisms and found seventeen negative, ten weakly positive and three intermediary positive reactions. Of the latter, the reactions tended to become negative when retesting was done in about one week.

Transfusion of Incompatible Blood.—Tominaga reports clinical and hematologic observations on the effects of therapeutic transfusions of 30 patients with various types of infection. After the blood group to which the recipient belonged was determined, a small amount (5 to 10 cc.) of incompatible blood from a donor was injected slowly by means of a glass syringe. The donor's blood, after first being rendered noncoagulable by sodium citrate (0.5 per cent), was mixed with the recipient's blood in a syringe and the combined fluids were then injected into the recipient's median basilic vein. Following the transfusion the patient's temperature showed a definite elevation, usually in about one hour, and then gradually subsided. In febrile patients decided changes in the temperature curve were encountered, but with improvement in general condition the temperature receded to the normal level. A slight increase in arterial blood pressure was noted after transfusion. The pulse rate usually increased up to 20 per minute, but no patient showed any weakness, irregularity or blocking. The respiratory rate was not noticeably affected. In a few instances there was a transient increase in urobilinogen excretion, but no hemoglobinuria, hematuria and anuria. These findings showed no definite correlation between the amount of transfused blood and the combination of blood groups, probably because of the small amount of blood employed. The reactions following the transfusion consisted of mild chills, occasionally accompanied by mild dyspnea and cyanosis, and—though rarely—stupor and other manifestations of shock. The latter group of symptoms, when present, were but transient, no permanent after-effects being observed. A definite relation of the reactions to the amount of blood given was noted, although it was difficult to determine any relation between the degree of agglutination and the extent of reactions. About five hours after a transfusion of 10 cc. the peripheral erythrocyte count increased by an average of 520,000 and by an average of 386,000 for 5 cc. per cubic millimeter of blood. After a temporary decrease on the third day, the red cell count again increased. The hemoglobin values showed parallel variations with the erythrocyte counts. Increased reticulocyte counts were evidence of bone marrow stimulation (0.23 to 0.48 per cent increase). The blood platelets also showed a tendency to increase (124,000 to 110,000 per cubic millimeter) but in a few instances a decrease was also noted. The increase in leukocyte count was at the level of 1,640-4,350, with a shift to the left, in most instances ocurring within five hours. The erythrocyte sedimentation rate fluctuated slightly but never exceeded 10 mm. The isoagglutinin titers exhibited no appreciable changes. The effect of transfusion of incompatible blood in patients suffering from acute pyogenic diseases was found to be favorable in that it improved the general clinical condition and shortened the course of illness. In patients with surgical tuberculosis the only effect was the production of transient fever followed by improvement in appetite and clearing of the sensorium. These observations led Tominaga to recommend, in cases in which it is definitely indicated, transfusion of incompatible blood, preferably in small doses (5 cc.) at frequent intervals. The effect of such transfusions is interpreted as being due to the stimulating action of the products of the hemolysis. This method of treatment may be regarded as a type of shock therapy. The transfusion of incompatible blood appears to be particularly useful when it is used as an interim treatment for the stimulation of hemopoietic organs in many conditions associated with anemia. In severe anemia adequate replacement can of course be accomplished only by transfusion of large amounts of compatible blood.

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THE STUDENT SECTION

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The Contribution of Liberal Education to Professional Studies

OLIVER C. CARMICHAEL, LL.D.

Chancellor, Vanderbilt University

NASHVILLE, TENN.

The discussions of premedical education recorded in the medical journals have dealt primarily with the content of the curriculum. Some appear to favor a program highly restricted with a large amount of science training, others insist on a broader and more liberal selection of subjects outside the science field. One would judge that the majority is in favor of the latter plan, though the reasons for this opinion seem rather vague and indefinite. My purpose in this paper is to analyze the nature of the liberal arts program and the sort of contribution it should make to the development of the student and hence to his preparation for professional study, with special reference to preparation for the study of medicine. Some such analysis should throw light on the question of the desirable background of education to be sought in the prospective medical student.

GOAL OF LIBERAL EDUCATION

Before one attempts to deal with the elements which compose the premedical curriculum, it is important to consider the qualities which the college years should develop in order to send to the professional schools properly qualified candidates. This raises the question of the aims and objectives of the college. Since some eight hundred colleges prepare students for medical schools it is perhaps presumptuous to attempt to state the goal of liberal education, for obviously there is wide variety of purposes and methods of achieving them in so many different institutions. Despite this fact there are certain relatively definite aims that are more or less clearly conceived by all these institutions that merit consideration in an effort to evaluate the significance of the arts college as preparation for medical education.

What are the colleges attempting to do for their undergraduates? In the first place, they hope to acquaint them with the broad fields of knowledge embraced by the humanities, the social science and the science divisions. A student must have some knowledge of the heritage from the past, the literature and language of peoples past and present, in order to understand the civilization of which he is a part and in the advancement of which he should share as a leader in his profession. If he is to take his place in a complex social structure and understand the intricate and involved human relationships with which he must cope, he must have some knowledge of social science, which through its several branches, sociology, economics, political science and history, seeks to give one an understanding of man and the currents and countercurrents at work in human society. Finally, without a knowledge of the natural sciences, the scientific method and the scientific advances which have transformed modern society, it is impossible to comprehend the basis of American culture and progress.

But as important as an understanding of the broad fields of learning is, it should be remembered that it is only a part of the real value which comes to one in one's college years. The acquisition of facts is but the first step in liberal education. Learning to think for oneself, to stand alone intellectually, to venture a little beyond the beaten path in the realm of ideas is by far the more important goal. Increasing emphasis is being given to this objective in the arts college. The results have been all too meager in the best institutions, and perhaps negligible in some, but to an extent they are in evidence in the stronger graduates of all institutions. As a test of the fitness of an applicant for admission to a medical school, intellectual initiative is more significant than the subjects covered in the undergraduate years. It is more difficult to measure than the knowledge of chemistry, English or history, but it is not impossible to discover this power and to what extent it has been cultivated.

Another quality which the arts college seeks to develop is intellectual curiosity. It is being recognized that if it fails to establish vital and

Read before the Thirty-Seventh Annual Congress on Medical Education and Licensure, Chicago, Feb. 17, 1941.

permanent intellectual interests it has failed in one of its chief tasks. The graduate who has not succeeded in discovering some definite interest in learning for its own sake has not been liberally educated. It is only the urge to know, the love of knowledge, that can drive one on to independent study after formal schooling is over. Without it one of the chief aids to successful professional study is lacking. The desire to learn in order to be able sometime to practice a profession is immensely strengthened by a highly developed urge to learn for the sake of knowing more about the subject of one's interest. Indeed, when the latter desire is so strong as to dominate the former the best results will be obtained. If committees on admission to medical or other professional schools would take into consideration this quality, in the attempt to judge the effectiveness of the applicant's college training, it might prove helpful.

SOCIAL UNDERSTANDING AND RESPONSIBILITY

In selecting men for the medical schools particularly there is another phase of the student's training and personality that should not be overlooked. Medicine is one of the great agencies of social progress. Men who enter the profession should have not only an understanding of its place in the social structure but deep seated and genuine social interests. It is difficult to see how one without broad human sympathies could succeed in a profession which on the one hand requires such intimate contact with individual human problems and, on the other, exerts so profound an influence on society as a whole.

Now one of the objects of education which is becoming more and more clearly recognized is the development of social understanding and along with it a sense of social responsibility. The great emphasis on the social sciences in recent years is evidence of that fact. It does not appear, from a study of the literature on the subject, that committees on admission have concerned themselves particularly with the depth and breadth of the social interests of those who seek admission to medical schools. Indeed, it is a fact worthy of mention that, while all premedical curriculums prescribe a reasonable number of courses in both the science and the humanities divisions of the arts college, few, if any, require any study of the social sciences. In all the discussions of the subject of premedical training there seems to be no one who has advocated a real requirement in the fields of history, economics, sociology or political science. A good case could be made out for the practical value of these courses for one who plans to practice medicine, but apart from that a broad background of social understanding is essential to a well rounded personality, which is clearly basic to success in medicine. Again, it is not merely knowledge of social problems that is important but a desire to make some contribution toward their solution. It is this which the arts college strives for. Incidentally, the professional schools should make some provision for continuing this interest in their students through the training which they provide. The time has come in American life when education on all levels must emphasize the obligations as well as the rights and privileges that belong to one who has had superior educational advantages.

FOREIGN LANGUAGES, HISTORY, MATHEMATICS

Thus far in this paper the emphasis has been on the more or less intangible and general values which liberal education contributes to professional studies. It might now be profitable to consider the significance of certain individual courses and their importance as elements in the educational background of the student who wishes to enter a learned profession. Obviously, it would be impossible to discuss all of them in detail. A few illustrations will suffice for the purpose of this discussion.

What are the values of foreign language study, Latin, Greek, French and German? The obvious reply is that Latin and Greek are needed in order to understand the meaning of the terms used, the vast number of words derived from them, and that modern foreign languages are essential in order to enable the student to read French and German articles in scientific journals. That is a partial answer, but it is by no means complete. Foreign language study gives one an understanding of one's own language and a facility in the use of it that can be gained in no other way. There is perhaps no subject so valuable as a means of developing accuracy of expression and hence accuracy of thought as this study. The ability to use words discriminatingly denotes the power of clear and precise thinking, for shades of meaning in the use of words means shades of thought. It is doubtful whether one ever knows anything thoroughly if one has not the words to express it concisely and exactly. The matter then of knowing one's own language well is more than merely an asset in conversation or public address. It is an indispensable element in clear thinking. It is this important contribution which the study of Latin and Greek or French and German makes to the intellectual evolution of youth which is often overlooked. It develops a sense of the value of words and a feeling for shades of meaning which are necessary to accurate and precise thought processes. Other values that might be mentioned are the practice in analysis and synthesis which is necessary in the translation of a foreign language and the habit of sustained mental effort required in the mastery of another tongue. In short, the qualities of mind so necessary in scientific studies of every kind are developed through foreign languages as through few if any other subjects. These intangible values are

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more significant than those more practical values that are usually cited.

Why should a prospective medical student spend (or waste) his time studying history? Would it not be much better if in its stead advanced courses in biology, chemistry or physics should occupy his attention? The answer to these questions naturally depends on what one considers the significance of historical studies to be. Reference has already been made to the importance of an understanding of the background of Western culture. But a study of history should provide much more than merely a knowledge of what the past has bequeathed to the present. It develops a sense of perspective that applies in the consideration of any problem. It deals with origins, with cause and effect, with precedents to any given situation. It cultivates a habit of mind essential to successful and effective study in any field. Quite apart from the knowledge acquired, the mental attitude which it develops manifests itself in the approach to all types of problems. Nothing is viewed as in and of itself alone. Any given fact is recognized as part of a pattern, and the natural inclination of the history student is to comprehend the pattern. This is a mark of the liberally educated person. It is an essential attitude for any one who expects to make a success in any of the learned professions.

Science subjects are accepted as prerequisites to entering medical college, and many believe that mathematics should be required. Ordinarily the reasons advanced are that chemistry, biology and physics provide the knowledge required in medical studies and that a modicum of mathematics is necessary to successful mastery of the sciences. These are valid reasons, but they do not account for some of the more significant contributions which these subjects make to later studies. The information acquired is secondary in importance to the habits of exactness and accuracy of thought which mathematics and science develop. Long hours spent in the laboratory experimenting with and proving the laws of physics and chemistry, and observing through the microscope the behavior of animal life, fixes in the mind of the student the nature of the scientific method and inculcates the scientific attitude so necessary to his later education. These intangible but nonetheless real contributions which the sciences make to the intellectual growth of the student are so frequently ignored in the attempt to evaluate their importance that it seemed worth while to call attention to them, despite the fact that they are recognized by all as essential elements in preparation for the study of medicine.

Fundamentally, then, the contribution of the arts college to the development of youth is far more than merely getting them acquainted with useful knowledge. Its emphasis is on values and a sense of values rather than on facts and information. Essentially its curriculum is a value-searching, value-creating program. In history, the classics, literature, foreign languages and philosophy there is a search for values, the significance of events (in history), an evaluation and understanding of the ideals and aspirations of ancient people (through the classics), the beauty of thought and expression (in literature), discrimination in the use of words (in foreign language study) and the evaluation of truth as sought by the philosophers (in philosophy). What more valuable asset could the student have than a well developed sense of values when he presents himself for admission to the medical school? This quality sought by the arts college is frequently missed. Not all students are capable of developing it. The task of the admission committees is to distinguish between those who are capable and who have taken advantage of the opportunities and those who were either unable or unwilling to attain the real goal of undergraduate education.

SUMMARY

To sum up briefly then the conclusion of the matter, it will suffice to say that the real contributions of the college to the medical school are those intangible qualities and powers which it is able to develop in its students. Intellectual independence and initiative, social intelligence and understanding, accuracy of thought and expression, a sense of perspective and of values, these are the qualities which have traditionally belonged to the liberally educated person; they are again being emphasized in the stronger institutions. As criteria for selection of students for professional schools they are more important than the subjects taken and the grades received as an undergraduate. Emphasis on these qualities and on the means of evaluating them on the part of admission committees would, I believe, result in improving the personnel of the medical schools.

The Origin of Great Clinicians.—There is no better student than the son of a medical father if the boy's heart is in the work, but none is worse than he who, not caring for, or even disliking, the practice of medicine, is urged on by a medical parent to qualify in order to take his place. Better even than the student who, having family traditions, takes to medicine almost by instinct is the boy who, lacking any such associations, determines, whilst still a child, that he will be a doctor. For, in this last case, he may have more than an ideal to study and to advance the science of medicine—he may have a real call to heal the sick and alleviate human suffering. It is from this class that the truly great clinician is derived. Often these students are what might be termed freaks in their families. They appear in every social stratum, and their early decision to become doctors seems often to be unrelated to any outside circumstances.—Jones, F. Wood, in Doctors in Shirt Sleeves, edited by Sir Henry Bashford, London, Kegan Paul, Trench, Trubner & Co., Ltd., 1939.

Digests and Reviews

THE CARE OF THE PATIENT

Condensation of a lecture on Medical Ethics, presented by Dr. Charles R. Austrian of the Johns Hopkins University, Baltimore, at Harvard Medical School, April 15, 1940, and published in the Diplomate, January 1941.

The student may be skilled in the sciences, facile with chemical and biologic technics and know the physical manifestations of disease, but he will not be a physician until he has developed a clinical sense. This is an acquired faculty based on broad knowledge, a retentive memory, a discriminating and orderly habit of mind, combined with an understanding of mankind. That instruments of precision or methods of chemical or physical analysis have been supplanting the clinical study of the patient is not surprising. These procedures are helpful but they are only accessories in the care of the patient.

Occupied by his interest in scientific methods, the doctor is apt to forget that the beginnings of disease are insidious, cause little disturbance of function and give no detectable signs. The affected person feels that he is not well, and he may seek advice first at a time when the most careful examination will fail to disclose an objective cause for his discomfort. His subjective sensations are the earliest manifestations of ill health. How little many of them are understood! Who among physicians has not labeled such a complainer a neurotic only to find later that disease had developed? The late William S. Thayer said "After twenty years I relabel my neurotics my diagnostic errors." There are many people with functional disorders who apparently have no organic disease, but until precise studies have established all the causes and the significance of pain, weakness, dizziness and palpitation the differentiation between a neurosis and an early stage of physical disease may be impossible.

The patient is endowed with a capacity to feel, to think and to act as an individual. He has an endurance, a reserve, a resistance peculiar to himself. He is identical with no other. Encouraged to tell what troubles him, listened to with sympathy, questioned intelligently, impressed by your interest in him, he will disclose the type of man he is; than this there is no single datum more valuable as a guide to correct diagnosis and proper treatment. However, if your attitude is cold and your questions are badly phrased, his response may be worded to conceal essential facts. The manifestations of a disease may vary and the factors responsible for an atypical response cannot be determined except through a better understanding of the patient as a whole.

In the clinic a patient may be content to be "a case," but in the home he regards himself as your patron; he has chosen you because of some aptitude he has heard that you possess. He expects your personal attention and solicitude, as well as your study that is his by right. The attention given to the patient's sensations and responses to his environment is as important in determining the outcome of minor ailments as are the remedies prescribed.

A sufficiently complete survey should be made of each condition until its nature is clear, but the routine performance of needless tests indicates a lack of skilful observation and thinking, dulls clinical acumen, penalizes patients, wastes time and gives the public an incorrect view of the cost of sound medical care. Do not expect mere elaboration of procedure to replace your clinical sense.

At the risk of being considered backward, learn better to look and to see. Observation, still the most informative of all clinical methods, seems so simple that it is practiced too little. To the observing eye a glance reveals the apparent age, size, color, nutrition, mood, changes in the skin, discomfort, clues of circulatory, pulmonary, abdominal and endocrine disease, and even of habits and occupation.

During your investigation avoid working by the clock, for haste causes errors of omission frequently more serious than those of commission. In giving advice be deliberate, cheerful and understanding, but sympathetic only so far as this will not be prejudicial to treatment.

A knack in carrying out what are considered nursing procedures is useful; the arrangement of pillows and rolls probably accomplishes as much for Rollier in his treatment of tuberculosis of the bones and joints as do the supports and extension used generally by others. If you can supply a hobby for idleness, you may convert a complaining parasite into a cheerful worker.

To gain the full cooperation of the patient in many cases you must tell him exactly the nature of his illness. Hard facts may be softened by careful phrasing.

When a patient is seriously ill, it is justifiable to express the hope that the chances for his recovery are better than they seem to be at the moment; but if he is fatally sick it is rarely well to indicate to him the outcome. There is no rigid rule that will meet all situations. The full truth should be told to some responsible relative or friend. Generally a partial truth is worse than a lie, but incomplete information told without distortion of fact will spare avoidable sorrow. There is no more helpful ability in time of crisis than skill to tell bad tidings.

Patients with functional nervous disorders are perhaps more numerous in private practice than

they are in the hospital. These patients will be your despair because of the obscure problems they may present or your delight because, cared for properly, they will recover; they cannot be dispatched with "There is nothing wrong with you."

In contrast, there are patients who are neither neurotic nor organically ill but still are not quite healthy. They practice moderation in all things yet they are hampered by fatigue, aches and pains. They do more than their capacity warrants; they try to pursue the ways of the vigorous and, unlike psychoneurotic patients, ignore their symptoms. Well balanced emotionally, occupied constructively, they are often the recipients of medicines instead of instructions as to how to live within the range of their capacities. They must be taught to realize that their bodies are sound but their reserve is low; they must be persuaded to curb ambition, to limit their activities and to replace medication with limited living that can still be useful. In these cases a new way of living must be sought, for an attempt to improve their general condition too much may result in complete disability. Nature shows the way when it slows him who has myocardial disease with an intermittent claudication and when it halts the tuberculous with lessened endurance.

The purpose of all you do in studying the patient is to relieve him of his symptoms. You must detail directions so clearly that an untrained aide can comprehend them. Uninfluenced by fashion, use measures as simple and inexpensive as possible without sacrifice of merit, but be ready to use new remedies if you have the means available to control their action. Avoid administration by injection when oral medication is as effectual. Endeavor to utilize accepted drugs, notwithstanding the enthusiastic claim made for the superiority of proprietary preparations. Be informed of therapeutic advances and, although quick to adopt new measures when their worth has been established, avoid prescribing those which have only novelty to commend them.

Finally, the care of the sick includes teaching them to live in accordance with the rules of hygiene in the fullest sense. If charged with the care of a patient who has a hereditary or contagious disease, teach him measures to prevent its transmission to others.

The functions of him who ministers to patients are to individualize them, to treat them rather than their diseases, to protect them from misguided direction, to guide them and their families in a way that will bring a good adjustment to an altered status with a minimum of strain and that will restore well ordered ways of life. As Trudeau said, "To cure sometimes, to relieve often, to comfort always," that is the job of the doctor.

THE STORY OF A SURGEON-ADVENTURER

Condensation of an article by Dr. Edgar L. Gilcreest, San Francisco, published in California Monthly, September 1940.

Seventy-six days out of Independence, Mo., in the year 1852, a dusty wagon train rumbled into Stockton, Calif. At the side of one of the wagons rode a man over 6 feet tall, erect, wearing a great black cape over his shoulders and displaying a well-being not usual to those who came west for gold. In one of the wagons lay his dying wife.

This picture introduces the story of Dr. Hugh Huger Toland, written by Dr. Edgar L. Gilcreest. Dr. Toland left a lucrative practice and position of esteem in South Carolina to come to California at the age of 46. He had graduated in 1827 at the age of 22 from the University of Transylvania in Lexington, Ky. He went to Paris in 1831 for further study with such masters of surgery as Dupuytren, Rousseau and Lisfranc. His colleagues had been Oliver Wendell Holmes, Bowditch and Bethune of Boston, and Pepper, Gerhard and Peace of Philadelphia. Dr. Toland's dexterity in operating, particularly for the relief of clubfoot and strabismus, and his classic methods of using lithotomy forceps, had brought him to the attention as early as 1841 of James Marion Sims of Montgomery, Ala.

When Hugh Toland purchased the Gwinn Gold Mine, the fortune he had brought with him was rapidly depleted rather than increased. He went to San Francisco to practice medicine and soon had a large practice. He saw in this period, it is said, a hundred patients a day in his office and made half as many visits to homes. Within a short time his annual income from practice amounted to $42,000. Toland's method was impressive. He had a gift for diagnosis. He read the patient's face. He knew what a tongue can show, how to listen to a chest, the story a pulse can tell. Critics sometimes claimed that Toland's methods were not always ethical. He had his own drugstore and but two favorite prescriptions, one consisting of various mixtures of potassium iodide, the other of mercury with nauseous drugs as adjuvants. He kept office hours in the morning for private patients and in the afternoon for clinic patients, for whom no charge was made for the prescription, but at the end of the corridor was the drugstore, and no one but his pharmacist could decipher the scrawls of Dr. Toland's squeaking pen. An idea of the volume of business done could be estimated from the row of prescription filled scrapbooks on the top shelf which encircled the room. Prescriptions were renewed at $5 a bottle, but he never gave out their contents except when teaching students.

As there was no fast transportation in those days, Toland did a large prescription business by mail. The miners in California and Nevada found it easier to write to him about their symptoms than to make the long journey by stage. Medicine was then forwarded to the miners by Wells Fargo & Co. Express, which collected the doctor's fees.

By 1864 Toland realized the fulfilment of a wish which he had long cherished, the founding of a medical school. Toland Medical College, a handsome brick and stone structure on Stockton Street between Chestnut and Francisco streets, at first was eminently successful and received the confidence of the public. However, a division occurred in the faculty which led after a few years to the formation of the Cooper Medical School. The county hospital, which had been next door to the Toland Medical School and was indispensable to its work, now was moved away and several important faculty members went over to Cooper Medical College, taking with them practically all the students. Unable to close this breach, Dr. Toland donated his school in 1873 with its furnishings and land to the University of California and it became an integral part of the university, and Dr. Toland remained the professor of surgery until his death.

If the advances in surgery that have been made since his time are considered, Toland was a great surgeon in his day. His assistant and successor, Dr. Robert A. McLean, said that "he possessed in a marked degree the qualifications we look for in a great surgeon—steadiness of hand and boldness combined with caution. The rapidity of his execution was remarkable and was based on a thorough knowledge of anatomy. Few surgeons possessed more manual dexterity. He was cool, imperturbable and decisive in execution. He had great poise in the midst of an unexpected emergency or eventuality and would, when circumstances demanded it, relinquish further procedure without a moment's vacillation. As an operator his success was proverbial." Although often generous and courteous to critics, when the welfare of a patient was at stake Toland occasionally would violate all the rules of medical ethics by refusing to protect a practitioner who had called him in consultation. A story handed down from Dr. Robert McLean has it that once when his colleague was late to a consultation and he could wait no longer, Toland learned from the patient that the diagnosis of the attending physician was an axillary abscess. Toland pinned to the patient's clothes before he left a note saying "Dear Doctor: Do not lance this patient's axillary abscess or he will at once bleed to death." It was, of course, an aneurysm.

Dr. Toland's work ran the gamut of general surgery. As early as 1858 he did trephining and thyroidectomies, ligated for aneurysms, repaired vesicovaginal fistulas, did radical bone operations for osteomyelitis, removed torn cartilages from the knee joint and did partial resections of the tongue with ligation of the lingual artery. He was also a plastic surgeon of no mean ability, and his knowledge of the fundamental principles of success in this field is impressive. According to Dr. McLean, Toland ligated the external iliac artery more frequently than any other surgeon of his time, and his cures following lithotomy were higher than any other surgeon. Yet, in spite of his adventurous spirit, Toland was conservative, as the following teaching shows: "A limb should never be amputated for ulceration of the soft parts unless disease of either the bone or joint existed, and very seldom even then."

Toland belonged to a generation of surgeons which is rapidly passing, and one which the specialist, Dr. Gilcreest believes, can never fill. Toland had the quality in common with such great figures as William Osler, John B. Murphy, Frank Billings and William J. and Charles H. Mayo to inspire patients with implicit faith, and that is an essential attribute of the successful practice of medicine.

A few of his patients are still living, and the impression that Dr. Gilcreest gained in conversing with them was this: "We remember him vividly as one who, above everything else, was kind and wise and who came to cure us. To us he was the doctor with all that the appellation conjured up in our minds at that time."

Comments

BOOKS RECOMMENDED

Hard work, faith in the principle of mutual aid and good emotional control are the benefits we should most desire by the way. Some of our help will come from friendships, some from books. Of books on the borderland of our common subject let me recommend a friendly shelfful. Osler's "Aequanimitas" and "An Alabama Student" and Osler's own favorite, Sir Thomas Browne's "Religio Medici," at once occur to me. Harvey's "Circulation of the Blood," Michael Foster's "Lectures on the History of Physiology," Fulton's "Selected Readings in the History of Physiology" should implement your textbook reading. For relaxation, Dr. John Brown's "Rab and His Friends," with his other essays and short stories, and Balzac's "Country Doctor." Darwin's "Expression of the Emotions in Man and Animals," Cannon's "Bodily Changes in Pain, Hunger, Fear and Rage" and Pavlov's "Condi-

tioned Reflexes" should be read before any page of a modern textbook of psychiatry is turned. Galton's "Enquiries into Human Faculty" and Kropotkin's "Mutual Aid" should set you thinking and talking. I would like to think that some of these old friends of mine, five or six of which are published in the Everyman edition, will become your friends and help to keep your science in perspective. Misapplied science, it would seem, is trying to destroy our race and all its priceless treasures of hand and mind. It must not and cannot succeed. And how grand it will be to be given the chance of applying our own science and our own humanity to the salvage and the mending of old treasures and to the discovery of new ones.—Ryle, John A.: *Cambridge University Medical Society Magazine*, Michaelmas Term, 1940.

THE LITERARY VALUE OF OSLER'S ESSAYS

With the recent publication of "This Generation," an anthology of selections from recent literature, Sir William Osler's chapter on neurasthenia from the 1930 edition of his "Practice" was included along with selections from Robert Frost, Edna St. Vincent Millay, Theodore Dreiser, Eugene O'Neill, Robinson Jeffers and James Joyce. "This Generation" was prepared in the Department of English of Pacific States University. This is not the first time, William White[1] states, that Osler's writings have been included in anthologies, but it is the first time that selections from his "Practice" have been used for their literary value. The most popular of Osler's essays has been "The Student Life," a part of which another anthology, "Reading and Thinking," included side by side with Oliver Wendell Holmes's "Autocrat of the Breakfast Table." No one can avoid, on reading Osler's essays, or even his "Practice," Mr. White says, coming to the conclusion that innumerable classical allusions and the wealth of literary flavor must have been born of a tremendously wide reading and research. In addition there is a diversity that is astonishing. This remarkable physician, teacher, essayist, lecturer, historian and bibliographer has books and essays in no less than six departments of the Los Angeles Public Library.

1. White, William: The Literary Physician: A Note on Osler's Essays, California & West. Med. 54:79 (Feb.) 1941.

FREEDOM TO THINK

We all pass through a stage of thinking that our generation in its day was a little wiser than the one that followed it. In this we are doubtless very often wrong, but I believe that my generation of medical students was more alive to the uses and interests and educational value of the debating and scientific criticism than the generation that came between the two great wars. Make every use of your opportunities here. Learn to speak in public and test for yourselves the mental stimulus of logical dispute.

You cannot afford to school yourselves in science alone. You must know something of men and movements too. You must qualify for citizenship as well as for your baccalaureate or doctorate in medicine. Whatever form our future state may take the doctor will always be a key-man in its organization. He must earn his freedom to think and to advise and must seek by every means in his power to become, like Grenfell of Labrador, like Balzac's "Country Doctor," like many a good physician who dies unsung after an arduous life devoted to the community, a man of ideals, a man of judgment and a man of action.—Ryle, John A.: *Cambridge University Medical Society Magazine*, Michaelmas Term 1940.

Correspondence

SIX PHYSICIANS SIGNED DECLARATION OF INDEPENDENCE

To the Editor:—In regard to your question in the Student Section of THE JOURNAL, February 22, page 793, concerning the physician who was one of the original signers of the Declaration of Independence, your readers may be interested to know that, besides Benjamin Rush, there were five other physicians who were signers. There were Josiah Bartlett and Matthew Thornton representing New Hampshire, Lyman Hall representing Georgia, George Taylor representing Pennsylvania and Oliver Wolcott representing Connecticut. Thornton and Taylor were born in Ireland.

The medical profession needs to know more medical history. Keep up the good work.

JOHN LABRUCE WARD, Asheville, N. C.

DO YOU KNOW WHAT PHYSICIAN—

1. Was regarded as the English Hippocrates?

2. Was chief sanitary officer during the building of the Panama Canal?

3. Led the movement which resulted in the establishment of the Army Medical School in Washington, D. C.?

The answers are on page 1332.

Medical College News

Medical schools, hospitals and individuals will confer a favor by sending to these headquarters original contributions, reviews and news items for consideration for publication in the Student Section.

Course in Military Medicine for Seniors

A course for senior students in the fundamentals of military medicine is being conducted at Albany Medical College, Albany, N. Y. The course is being devoted to general problems in aviation medicine, naval warfare and chemical warfare. The purpose is to give a general background of the principles involved rather than highly technical instruction. The instructors, it is expected, will include officers from the War Department—medical, aviation and chemical warfare services—as well as members of the staff of the Albany Medical College.

New Fraternity Home at Texas

The Phi Chi medical fraternity has begun construction on a $50,000 brick veneer house at the medical branch of the University of Texas, Galveston, which will accommodate about fifty members. The study and sleeping quarters will be arranged around an open court. The home will have also a library, lecture room, game room, living room and dining room. About $1,600 has already been spent on kitchen equipment for the new house.

Premedic Prize at Ohio State University

The Ohio Alpha chapter of Alpha Epsilon Delta, national honorary premedical fraternity, has established a $50 prize contest to stimulate original work and creative writing among premedical students at Ohio State University. Hugh E. Setterfield, Ph.D., chapter adviser and associate professor of anatomy at the college of medicine, is chairman of the awards committee and announced the establishment of the prize. Half of the award is being provided by Dr. Leslie L. Bigelow, professor in the college of medicine. The prize will be awarded at the June commencement for the best paper on any phase of study or research in the College of Arts and Sciences in its relation to preparation for the study of medicine.

Wayne University

The newly organized student-faculty glee club of thirty-six members at Wayne University College of Medicine, Detroit, has made its first public appearance and was enthusiastically received. The director of the glee club is Leroy W. Juhnke. The guest speaker at the student convocation of the college of medicine, February 10, was Dr. Armand J. Quick, associate professor of pharmacology at Marquette University School of Medicine, Milwaukee. Dr. Quick's subject was "A Discussion of Hepatic Functions and the Significance of Liver Function Tests."

New Members of Louisiana's Circle

The annual ceremony of the presentation of keys to new members of "The Circle" at Louisiana State University School of Medicine, New Orleans, was held February 14. The new members are Frank Arbuthnot Cain '41, Saul Sheldon Daiell '41, Mitchell Alexander Brucker '41, Thomas Malcolm Deas '41, Dioniseus Vincent Cacioppo '42, Louis Allen Lazarowitz '42 and William Emmet Wilkinson Jr. '42. Emanuel Dubow '41, Spurgeon Meek Wingo '41 and Norman Cooper Woody Jr. '41 were elected to membership last spring as the highest ranking students in the (then) third year class. The principal address was presented by Dr. George W. McCoy, director of the department of preventive medicine at the university, whose subject was "Landmarks and Horizons in Public Health."

The Circle is the honor scholastic society at Louisiana State University School of Medicine, membership being limited to the upper tenth of the fourth year class and the three highest ranking juniors in the third year class. The advisory committee from the faculty at present consists of Dr. B. I. Burns, dean, Dr. J. D. Rives, professor of clinical surgery, and Dr. Charles Midlo, assistant professor of anatomy.

University of Tennessee

Dr. Fred L. Adair, professor of gynecology and obstetrics at the University of Chicago, Department of Medicine, gave the address to the December 1940 graduating class at the University of Tennessee College of Medicine, Memphis. The graduation address to the March 1941 class will be delivered by Dr. Sam L. Clark, professor of anatomy at Vanderbilt University School of Medicine, Nashville. Dr. Simon Rulin Bruesch, at present an intern at Passavant Memorial Hospital, Chicago, will become an instructor in anatomy at the University of Tennessee College of Medicine, beginning with the next fall quarter, and Arthur R. Lack Jr. '42, now a senior at Stanford University School of Medicine, San Francisco, will become an instructor in anatomy at the college of medicine beginning with the summer quarter.

"DO YOU KNOW WHAT PHYSICIAN"

Following are answers to the questions appearing on page 1331:

1. Thomas Sydenham (1624-1689). Sydenham rejected the traditional dogmas of medicine and insisted that observations should have precedence over theory. He studied the natural histories of diseases and gave clear accounts of the diseases of his day and thus gained the title of founder of modern clinical medicine. He is credited with the first diagnosis of scarlatina and with the modern definition of cholera. Sydenham graduated from Oxford in 1648, continued his researches at Montpellier and in 1663 passed the examinations of the College of Physicians, which permitted him to practice in London.

2. Dr. William Crawford Gorgas, who was later Surgeon General of the U. S. Army throughout most of the World War and was President of the American Medical Association in 1909-1910. Dr. Gorgas was born in Alabama and received his degree from Bellevue Hospital Medical College in 1879. He retired from the army on Oct. 3, 1918, having reached the age limit, and in May 1920 left for the west coast of Africa to head a sanitary commission of the Rockefeller Foundation. While en route in London he was stricken with cerebral hemorrhage and died there on July 4, 1920.

3. Surgeon General George M. Sternberg, who also had the honor of recommending the appointment of a board of army officers for the study of the cause of yellow fever in Cuba. After a famous series of experiments, the board discovered that a certain species of mosquito transmitted yellow fever. Dr. Sternberg was born in New York in 1838 and graduated from the College of Physicians and Surgeons, New York, in 1860. He was President of the American Medical Association in 1898.

Book Notices

Epitome of the Pharmacopoeia of the United States and the National Formulary with Comments. Corrected and Revised in Accordance with the First and Second Supplements of the Pharmacopoeia, Eleventh Revision, and the First and Second Correction Lists of the National Formulary, Sixth Edition. Prepared for the Use of Physicians under Authorization of the Council on Pharmacy and Chemistry of the American Medical Association by a Committee of Council Members: Robert A. Hatcher, Phar.M., M.D., Chairman of the Committee, C. W. Edmunds, M.D., Professor of Materia Medica and Therapeutics, University of Michigan Medical School, Ann Arbor, Morris Fishbein, M.D., Editor of The Journal of the American Medical Association, Ernest E. Irons, Ph.D., M.D., Clinical Professor of Medicine and Chairman of the Department of Medicine, Rush Medical College, University of Chicago, and Paul Nicholas Leech, Phar.M., Ph.D., Secretary of the Council on Pharmacy and Chemistry. Sixth edition. Cloth. Price, 60 cents. Pp. 246. Chicago: American Medical Association, 1940.

This edition is revised in accordance with the second supplement of the United States Pharmacopeia. As in the case of previous editions, it is prepared by a special committee of the Council on Pharmacy and Chemistry and is published under the authorization of that council. All the official preparations are listed, along with an evaluation of their usefulness or uselessness in modern therapeutics. Asterisks indicate those items which, in the opinion of the Council, deserve sufficient recognition to be included in the latest edition of Useful Drugs. Unlike Useful Drugs, this volume does not deal with any but the official preparations. The various official drugs are listed alphabetically, according to their Latin names, and the official preparations of those drugs listed thereunder in each case. The extensive index is based principally on the English names of the official drugs. This edition deserves the popularity enjoyed by the previous editions.

Abdominal Operations. By Rodney Maingot, F.R.C.S., Senior Surgeon to the Southend General Hospital, and to the Royal Waterloo Hospital, London. Volumes I and II. Cloth. Price, $18, per set. Pp. 803; 807-1385, with 298 illustrations. New York & London: D. Appleton-Century Company, Incorporated, 1940.

Abdominal surgery has made spectacular progress in the past fifty years. Its contributions to clinical medicine and pathology are well known. The physiology and pathologic variations of the intestinal tract have in recent years become of increasing importance to the surgeon. Even the application of roentgen rays to the diagnosis and evaluation of intra-abdominal conditions is almost entirely limited to the past quarter century. These factors must be heeded when books such as this are considered. The assessment, recapitulation and condensation of surgical endeavor now constitute an important and vital task.

The author begins with some cogent remarks on the proper choice of incisions. A few of the more useful incisions are described together with several methods of closure. The subject of drainage and care of wounds is considered. Maingot's attitude is conservative, although he advocates removal of drains sooner than some surgeons feel desirable. The first volume is then devoted to diseases of the stomach, duodenum, spleen, pancreas, gallbladder and bile ducts. A chapter is given to congenital pyloric stenosis in infants. In its thoroughness, yet brevity of presentation, this chapter is exemplary. Preoperative and postoperative care, diagnostic features, pathology, symptoms are all combined in satisfying fashion. The interspersion of historical sidelights adds color to the text.

The topic of peptic ulcer occupies the largest single portion of the book. The author, while recognizing a possible similarity in etiology, wisely separates the discussion of duodenal and gastric ulcer. The tendency of gastric ulcer to become malignant cannot be overlooked. The operative technics presented are thoroughly modern, and each is accompanied by some mention of its indication and value. The great number of names and technics associated with gastric surgery is a source of much confusion. The fact that a certain operation has been performed does not necessarily make it valuable. The proper application of surgical procedures for the treatment of ulcer is a delicate matter requiring keen judgment even more than skill. It is pleasingly evident that the author has threaded through the maze with great finesse. He is highly in favor of partial gastrectomy for the treatment of peptic ulcer but points out that other procedures have much to offer if properly used. Although mention should have been made of hiatal hernia as a source of gastric disorder, this section is a superb effort.

The portions devoted to diseases of the spleen and pancreas are completely adequate and modern. There are many practical points in the latter chapters; for instance, the brief section on the care of T tubes. These are not dismissed with the casual remark that they are to be removed in so many days. Rather, enough is said to demonstrate their possible value in the postoperative management of biliary tract disease.

The second volume is devoted to diseases of the liver, appendix, peritoneum and intestine. There are also chapters on hernia and postoperative chest complications. The excellent presentation continues in this volume. The value of such operations as omentopexy is considered. Detailed suggestions are recorded for the treatment of subphrenic abscess and for hepatic abscess. The treatment and concept of appendicitis are along usually accepted lines. The obstructive features of appendicitis are not discussed with sufficient emphasis. The replenishment of electrolytes and fluids in those diseases of the alimentary tract in which drastic losses occur receives due attention. The ileocecal valve as an important factor in obstruction of the large intestine is not stressed, although the preoperative preparation of patients with this disturbance is well presented. A large part of the second volume is devoted to cancer of the colon.

The whole is an excellent summary of accepted indications and technics. The general form and make-up are splendid. Illustrations are clear and abundant. The two volumes are treated as a single book with continuous pagination regardless of chapter or part. This feature facilitates cross reference. References are numerous and apt; sources are given directly after the author. Thus a good deal of the modern history of surgery is delineated. There is a plethora of witty and sagacious quotations from various noted authorities, well salted with pithy remarks by the author. It is evident that this work is a remarkable contribution to surgical literature and is destined to achieve a deservedly great popularity.

Heart Failure. By Arthur M. Fishberg, M.D., Associate in Medicine, Mount Sinai Hospital, New York City. Second edition. Cloth. Price, $8.50. Pp. 829, with 25 illustrations. Philadelphia: Lea & Febiger, 1940.

This book is a worthy successor to the first edition and will occupy the same high position of authority that was accorded its predecessor. Attention should again be directed to the fact that this work is an exposition only of heart and circulatory failure. Heart disease is discussed only in reference to failure of the heart or peripheral circulation. This method of dealing with the subject permits the author to limit sharply his discussion and, more important, it permits him to discuss his subject with great thoroughness and accuracy within a single volume. Every important fact pertinent to the cause, recognition or treatment of heart failure will be found in this book.

The discussion is initiated with a description of the concept and the types of circulatory failure. The cardiac output, blood velocity and volume, under normal conditions and in failure, are then set forth. The arterial and venous phenomena are similarly dealt with. Respiratory symptoms, edema and cyanosis are next taken up. The effect of failure on the lungs, liver and spleen, kidney and central nervous system come next in order. Several chapters are now devoted to the behavior of the heart itself under the stress of failure from a variety of causes. An important chapter follows dealing with peripheral circulatory failure and its differentiation from heart failure. The treatment of heart failure in its various stages and types is then discussed, and the final chapter tells of the treatment of peripheral circulatory failure.

The manner in which the author has dovetailed the various technical procedures into the clinical observation of the patient is especially to be commended. He shows how observations on the cardiac output, the circulation time, the venous pressure and similar measures may be easily applied to the patient in heart failure and how these measures offer an accurate guide to the clinical progress or the lack of it. It is in the application of these measures that much has been added in this edition. He discusses, for instance, the effect of septal defects on the tests for circulation time. He has added some information relative

to regional differences in venous pressure as well as a discussion of normal values of the venous pressure by the direct method. There has also been added a paragraph on postural hypotension. These few examples will show how meticulously careful the author has been in reediting the work throughout.

The usual excellent bibliography is again evident.

The book may be unreservedly recommended as a reference work for students and practitioners. All who are particularly interested in disease of the circulatory system should be thoroughly familiar with it.

The Diagnosis and Treatment of Diabetes. By W. Wilson Ingram, M.C., M.D., F.R.A.C.P., Director, Institute of Medical Research, Royal North Shore Hospital, Sydney. Third edition. Cloth. Price, 6s. 6d. Pp. 150. Sydney & London: Angus & Robertson Limited, 1940.

The foreword, by Prof. C. G. Lambie of the University of Sydney, emphasizes the intention of the author, a famous Australian physician, to supply a manual intended primarily for the use of the general practitioner in Australia. The book therefore deals with the arrangement of diets of less caloric value than those used in America, an arrangement that the author feels is more practical for people living in subtropical Australia. The book includes an account of the use of high carbohydrate diets, a dietary scheme that has many practical advantages. Dr. Ingram advocates a rearrangement of the carbohydrate allowance, reducing the breakfast allowance so that the carbohydrate content of the diet may be spread throughout the day, an increased amount being allowed for supper in order to meet the maximum absorption of the protamine zinc or modified insulin. This method of rearrangement of the carbohydrate portion of the diets to meet the absorption of the modified insulin has not been generally adopted in the larger clinics of America, although under the special conditions which exist in Australia it may be effective. The author claims that all unmodified insulin should be injected twenty to thirty minutes before, not after, each meal. However, in discussing the cases of diabetic patients who are making sea voyages, he writes "Patients taking large doses of insulin have partaken of the meal only to lose it almost immediately, with resulting severe and dangerous hypoglycemia." Such reactions might result in serious accidents in the presence of coronary disease. Then, in these cases at least, why not give the insulin after the meals, as is the growing custom of many American doctors? The chapters on complications, coma, arteriosclerosis and infection, as well as the food tables are of much value for any busy general practitioner. The book on the whole is excellent, being simple and practical, so that it can be readily referred to by any practitioner.

Report of the Secretary of Agriculture 1940. U. S. Department of Agriculture. Paper. Pp. 184. Washington, D. C.: Government Printing Office, 1940.

The work of the Farm Security Administration in providing medical care for their clients was developed because surveys in a Southern state revealed that 50 per cent of the borrowers who failed to keep up their payments were victims of bad health. A recent study of one hundred low income families in two Southeastern counties disclosed one thousand three hundred and seventy-three ailments among five hundred and seventy-five persons. The ailments included 132 cases of rickets among children, 31 cases of suspected tuberculosis, 14 cases of pellagra, 288 cases of diseased tonsils, three hundred and sixty individuals with defective teeth and one hundred and twenty-four with defective vision. The medical plans of the Farm Security Administration are supported by loans extended to the families and call for free choice of physician and the pooling of funds. Most families pay from $20 to $30 a year. They choose their doctor from among local cooperating physicians and receive medical benefits which usually include (1) ordinary medical examination, diagnosis and treatment, (2) emergency surgery necessary to save life or limb, (3) emergency hospitalization, (4) obstetrics with antepartum care, delivery and postpartum care, (5) ordinary drugs dispensed or prescribed by the attending physician and (6) dentistry prescribed by the attending physician to relieve disease or pain. Doctors, hospitals and dentists are paid out of the general funds. Cooperating physicians have collected an average of 64 per cent payment on all bills submitted. Such medical care plans are now operating in four hundred and twenty-seven counties in twenty-six states and affect sixty-five thousand one hundred and fifty-seven low income farm families, or about three hundred and thirty-nine thousand persons.

Green's Manual of Pathology. Revised and Enlarged by H. W. C. Vines, M.A., M.D., Director of the Charing Cross Hospital Institute of Pathology, London. Sixteenth edition. Cloth. Price, $8.50. Pp. 1,108, with 701 illustrations. Baltimore: William Wood & Company, 1940.

One is impressed by three statements in the first chapter: "Vital processes are not governed by man-made classifications and subdivisions . . ." Writing of "similar signs and symptoms it is often quite possible to forecast the course the disease is likely to take. This is called prognosis, but it is no more than a forecast of events in the average case. . . ." "The powers of accurate observation and of critical judgment can only be developed by long and often painful experience, because the training of these faculties is consistently ignored in all forms of early education." The spirit of the truth of these statements exists throughout this book, which, unlike most textbooks, deals with the great generalities of disease rather than picturing conditions as unchanging entities. One is left with the feeling that morbid conditions are not as distinct as many textbooks and teachers make them. The book is well written but, like most textbooks, retains many old concepts that would not remain with us if textbook writers really could be familiar with the latest research on all subjects they write about. The illustrations, largely photographic, are good. The author refrains generally from giving original sources and credit to original and modern investigators. A student might well read this book with many others. This would teach him that different stories in medicine, like fiction, are written on the same theme.

Manual of Specifications for the Purchase of Hospital Supplies and Equipment. Prepared by the Committee on Simplification and Standardization of Hospital Furnishings, Supplies and Equipment of the Council on Hospital Planning and Plant Operation of the American Hospital Association. Bulletin No. 203. Fabrikoid. Price, $5. Pp. 734, with illustrations. Chicago: The Association, [n. d.].

This manual is useful in the purchase of hospital supplies and equipment. It presents specifications for three hundred and sixty-two commodities used by hospitals. It is not contemplated that the hospital buyer will be limited to the details of the specifications presented. He is furnished a description of materials, workmanship and construction details which serve as a guide but still permit him to make such alterations as may be necessary to suit the particular use for which the commodity is intended. Consideration is given to simplification and standardization in the interest of economy. There are four special chapters on purchasing, testing, storage and standardization of commodities.

Essentials of Nutrition. By Henry C. Sherman and Caroline Sherman Lanford, Columbia University, New York. Cloth. Price, $2.50. Pp. 418, with 34 illustrations. New York: Macmillan Company, 1940.

This book by Dr. Sherman and his daughter is a thoroughly readable and adequate review of the essentials of nutrition. Scientific terms which are not reducible to everyday words are clearly defined in a glossary. After an introductory chapter on the far-reaching significance of the newer knowledge of nutrition on the improvement of life, the subject matter of the book is divided in four sections: (1) the energy aspects of nutrition, (2) the proteins and their amino acids, (3) the mineral elements and (4) the vitamins. The last chapters of the book are concerned with food costs and the values and the problem of better nutrition for the individual. Tables showing the protein, fat, carbohydrate, calcium, phosphorus, iron, vitamin A, vitamin C, vitamin B_1, riboflavin and energy value of an extensive list of common foods are provided. These tables represent quantitative data from evidence available to the authors up to the end of February 1940.

This book is recommended to all persons interested in an up-to-date review of the essentials of nutrition. It is especially helpful to persons who have no special training in science and are interested in knowing the relation of food to health. The exercises and suggested reading lists at the end of each chapter make the work useful as a textbook for college or adult education classes.

Nurses Handbook of Obstetrics. By Louise Zabriskie, R.N., Director Maternity Consultation Service, New York City. Sixth edition. Cloth. Price, $3. Pp. 740, with 395 illustrations. Philadelphia, Montreal & London: J. B. Lippincott Company, 1940.

The author is undoubtedly convinced that nurses should know not only all about nursing but also much about the practice of medicine, including obstetrics. In its seven hundred and forty closely printed pages is much about obstetrics which is irrelevant for nurses. In the preparation of the book, the author enlisted the aid of fourteen contributors who wrote brief sections on such subjects as developmental anatomy, the use of roentgen rays in obstetrics, the Bay Jacobs forceps, a new manikin, prenatal and early postnatal phenomena of consciousness and the menopause. The vast majority of the illustrations were borrowed from other books, institutions, physicians and commercial firms. Some of the illustrations do not belong in a book for nurses, and a few have no bearing on obstetrics. There are even illustrations of clothing for grown-up children, including windbreaks which may be used for a child when playing or walking in the snow. The parts devoted to actual nursing are unsurpassable.

Methods of Treatment. By Logan Clendening, M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas, Kansas City, Mo., and Edward H. Hashinger, A.B., M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas. With Chapters on Special Subjects by J. B. Coxhead, M.D., et al. Seventh edition. Cloth. Price, $10. Pp. 997, with 138 illustrations. St. Louis: C. V. Mosby Company, 1941.

The seventh edition of this well known work is supplemented by the addition of a co-author and a number of contributors. Entirely new sections have been added on chemotherapy, anesthetics and the treatment of some diseases. Many sections have been completely rewritten. There are also references to new drugs such as dilantin and heparin. The work manifests the special interests of Dr. Clendening in its historical and literary references. The section on psychoanalysis is somewhat elementary and perhaps many psychoanalysts would call it distorted. Indeed, it might be questionable whether or not such an unsatisfactory portion of the book might not better be eliminated. Elsewhere the volume is marked throughout by good common sense and will be found most helpful to every practicing physician.

French-English Science Dictionary for Students in Agricultural, Biological and Physical Sciences. By Louis De Vries, Professor of Modern Languages, Iowa State College, Ames, Iowa. With the collaboration of Members of the Graduate Faculty. Fabrikoid. Price, $3.50. Pp. 546. New York & London: McGraw-Hill Book Company, Inc., 1940.

In addition to words pertaining to the agricultural, biologic and physical sciences, this dictionary contains many literary terms, forms of irregular verbs and about five hundred common idioms. There are forty-three thousand entries in all. According to the author, not all names of animals, insects, plants and chemical compounds are included. Because of the scope of the work, medical terminology is necessarily limited. Typography is excellent and the volume easy to handle. It will be welcomed by scientific workers because of the great lack of material of this type.

A Guide to Human Parasitology for Medical Practitioners. By D. B. Blacklock, M.D., D.P.H., D.T.M., Professor of Tropical Hygiene, Liverpool school of Tropical Medicine, the University of Liverpool, Liverpool, and T. Southwell, D.Sc., Ph.D., A.R.C.Sc., Director of Fisheries to the Governments of Bengal, and Bihar and Orissa. Fourth edition. Cloth. Price, $4. Pp. 259, with 124 illustrations. Baltimore: William Wood & Company, 1940.

The publication of the fourth edition of this authoritative handbook is indicative of its usefulness, which depends in part on its brevity, succinctness and diagrammatic figures. This edition contains important modifications in the life history of Strongyloides stercoralis and additions to the section on Filarioidea of Microfilaria malayi, Brug, 1927, which has been distinguished from M. bancrofti and has been found widely in Malaya, the East Indies, India and China.

Hot Tuberculosis Mortality in 46 Large American Cities for Year 1939. Tuberculosis Deaths Allocated to Residence. Proportion of Deaths Among White and Negro Residents. Paper. No pagination. New York: New York Tuberculosis & Health Association, 1940.

The tuberculosis death rate in forty-six large American cities having a total population of 31,715,186 has declined from 62.0 in 1938 to 59.4 in 1939 per hundred thousand of population. There is not only a decline in the rate but an absolute decline in the number of deaths from 19,509 in 1938 to 18,799 in 1939. The variation between cities is striking. Akron, Ohio, and Minneapolis have rates of 26 and 31 respectively. Detroit with 58 and Toledo with 60 are representative of the average for the United States, while Memphis with 103 and San Antonio, Texas, with 153 are at the other extreme. While Negroes make up but a little over 10 per cent of the population, they suffered 32 per cent of the deaths, in contrast with 68 per cent for white persons, who constitute almost 90 per cent of the population.

Official and Tentative Methods of Analysis of the Association of Official Agricultural Chemists. Editorial Board: W. W. Skinner, Chairman. Committee on Editing Methods of Analysis: E. M. Bailey (Chairman), L. E. Warren, J. W. Sale, G. G. Peary, E. A. Lepper and Marian E. Lapp. Fifth edition. Cloth. Price, $5. Pp. 737, with 61 illustrations. Washington, D. C.: The Association, 1940.

This edition marks another step in the standardization of chemical and physical methods of control and research in agriculture and related fields by the Association of Official Agricultural Chemists. A review of the fourth edition (THE JOURNAL, May 15, 1937, p. 1742) covered the general subject matter. The present volume has been expanded to more than seven hundred pages, with the addition of subject matter for chapters on fish and other marine products, vitamins, microbiologic methods and microchemical methods. Significant additions have been made to chapters on drugs, dairy products, grain and stock feeds, standard solutions, and oils, fats and waxes. The material is presented in a condensed form, covering a large variety of subjects. It is a valuable addition to the analyst's library.

Rose & Carless Manual of Surgery. American (Sixteenth) edition edited by William T. Coughlin, B.S., M.D., F.A.C.S., Professor of Surgery and Director of the Department of Surgery, St. Louis University School of Medicine, St. Louis. From the Sixteenth English edition by Cecil P. G. Wakeley, D.Sc., F.R.C.S., F.R.S.E., Senior Surgeon, King's College Hospital, London, and John B. Hunter, M.C., M.Chir., F.R.C.S., Surgeon, King's College Hospital. Cloth. Price, $9. Pp. 1,680, with 1,034 illustrations. Baltimore: William Wood & Company, 1940.

This textbook, which has provided instruction in the fundamental principles of surgery to many thousands of medical students throughout the world, has been again rather thoroughly revised. Moreover, many changes have been made to adjust the text to American teachings and practice of surgery. Sections dealing with basic sciences, such as bacteriology and hematology, have been entirely rewritten and somewhat shortened. The entire text has been brought up to date, particularly with regard to abdominal surgery, surgery of the nervous system and traumatic surgery. The chapter on war surgery, which the authors mention in the preface, is not contained in the book sent the reviewer. This volume should continue to be a leading textbook for instruction of medical students and an excellent reference book for the general practitioner.

A Study of the Results of Treatment in 1,100 Cases of Lobar Pneumonia. By Hugo Mella, M.D., Postgraduate Instruction and Medical Research Division Medical and Hospital Service, Veterans Administration, Washington, D. C. Paper. Pp. 37. Bedford, Massachusetts: Occupational Therapy Printing Department, Veterans Administration Facility, 1940.

This booklet summarizes two years' experience in treating some 1,100 patients with lobar pneumonia in Veterans Administration facilities. The mortality, leukocyte counts, types of treatment and other features are analyzed in tables and summarized.

Poems of a Doctor. By Edward Lovell Stewart, M.D. Cloth. Price, $2. Pp. 157, with illustrations by Charlene Blackburn. Kansas City, Missouri: Brown-White Company, 1940.

The author has been practicing medicine for thirty-seven years and nearly all of that time has been a professor in a dental college, as well as a writer of verse. He loves rhyme and rhythm and has a facile pen, although he wrote at odd times for three years on his epic ballad "The Mongrel Crew." He often stays after his teaching period at the dental college to recite poems before his class. His poems are human, understandable and enjoyable, and there is one for almost every occasion. Some of the titles are "The Doctor's Lunch," "The Christmas Card," "We'll Clean the Attic Out," "Good Night," "My Neighbor," "The Shooting of 'Faro Dan,'" "Our Nell," "The Beggar" and "The Tree."

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

SULFANILAMIDE OINTMENT

To the Editor:—In Queries and Minor Notes in The Journal, January 25, I note a rather elaborate formula for making a satisfactory sulfanilamide ointment. My druggist incorporates sulfanilamide directly in a petrolatum base as well as an aquaphor base without any difficulty. Could you tell me the advantage of going to all the trouble laid out in the procedure described?

Joseph W. Shaw, M.D., Seattle.

To the Editor:—In reading over the query entitled "Ointment Base for Sulfanilamide" the druggist here does not have any knowledge of what sodium alginate is or where it can be obtained, so I would like that information. He suggested this formula, and would like your opinion on it: 10 parts of sulfanilamide in 25 parts of almost boiling water; filter; add to 100 parts of hot starch solution; cool and add 15 parts of hydrous wool fat and 50 parts of petrolatum. Why was sodium chloride added to the formula? Could it be mixed with a cod liver oil base ointment and get desired results?

George U. Ivers, M.D., Fargo, N.D.

To the Editor:—In the January 25 issue of The Journal is an answer to a query on an ointment base for sulfanilamide which suggests the use of sodium alginate. This product is new to me. What is it? Have any studies been made on the toxicity of this product? Can it be taken internally?

Adolph Meltzer, M.D., Worcester, Mass.

ANSWER.—The ointment formula presented in THE JOURNAL, January 25, was prepared with the idea in mind of getting a base for sulfanilamide and its derivatives which would not be greasy and would be nonirritating. By utilizing such a base, one can obtain a smooth ointment. Sodium alginate of the best grade should be used, as there are several commercial grades. It can be obtained from Kelco, 31 Nassau Street, New York City. Sodium chloride was added to the formula because it seems to act as a stabilizer. Hydrous wool fat or cod liver oil base ointments are not used because at times a tendency for such sulfanilamide ointments to "cake" in wounds has been observed. The type of ointment described in THE JOURNAL has been used extensively in ophthalmologic work and has shown itself to be nonirritating and nontoxic when applied to the conjunctiva, sclera and cornea. There seems to be no good reason for prescribing sodium alginate for internal use.

TREATMENT OF PARKINSON'S DISEASE—WHOLE PITUITARY GLAND

To the Editor:—I have a patient with "Parkinson's disease." For this condition the English translation of Dr. Alfred Martinet's textbook (Clinical Diagnosis, Philadelphia, F. A. Davis Company, 1924) recommends the extract of the whole pituitary gland. I am eager to try this, as my patient has had from other physicians almost every medicament save this one without beneficial results, but my trouble is where to get this product and full directions about the dosage and time and number of doses to be given; in other words, a general plan of treatment with this extract. It may not be amiss to add that if there has been anything developed more recently for the malady and one which would give better results I would be glad to hear from you relative to it and the literature containing the plan of treatment.

W. R. Knoefel, M.D., Hot Springs, Ark.

ANSWER.—Whole pituitary gland may be obtained by any pharmacist in this country. The whole gland is not listed in the Pharmacopeia (XI, 1936) but does appear in the National Formulary (VI, 1935). It is obtainable as a desiccated powder. The drug is best given by injection, although slight effects may be expected after oral administration. Among other effects, it acts on the small muscles of the body, causing a rise in blood pressure, a stimulation of the uterus and increased intestinal peristalsis. The posterior lobe principle, moreover, has a slight antidiuretic effect and is useful in diabetes insipidus.

It would seem that there is no good reason for giving the whole gland preparation as recommended by Martinet. Even solution of posterior pituitary, moreover, would not be expected to affect the voluntary musculature, which is primarily disordered in Parkinson's disease. The lesion of paralysis agitans is usually considered as being in or near the basal ganglions of the brain, giving rise to the extrapyramidal symptoms. Practically all the symptoms of paralysis agitans can be accounted for by difficulty in the use of the voluntary muscles. If the posterior lobe has no effect on this musculature, it seems unlikely that a whole gland preparation would be of any benefit in the treatment of Parkinson's disease.

Many glands in addition to the pituitary have been tried in the treatment of paralysis agitans. All have universally failed in the experience of most judges. A recent report is that of Wilson: "Since the disease usually starts after the climacteric in women, or at an early involutional phase in men, any chance of staving off its progress by resort to glandular, in particular perhaps to gonadal, extracts seems therapeutically sound, but the results in my personal experience have never been good." Wilson's experience (Neurology, Baltimore, William Wood & Co., 1940, vol. 2, p. 804) is the same as that of many other physicians throughout the world.

Other forms of treatment are no more effective in curing the disease than pituitary; however, a number of drugs, particularly of the atropine series, are moderately useful in controlling the rigidity of the voluntary muscles, which is such a frequent and distressing feature of the disease. Two drugs widely used are stramonium and scopolamine hydrobromide. The stramonium is given in pills of stramonium leaves, 2½ grains (0.15 Gm.) from 4 to 12 pills a day. Scopolamine hydrobromide is used in pill form, 1/100 grain (0.6 mg.), 1 or more a day. As scopolamine sometimes causes severe mental perturbation with irrational behavior in sensitive patients, it is wise to begin with a smaller dose such as 1/200 grain twice a day and gradually increase the dose if the medicine is well tolerated. Some patients are known to take as much as 1/50 grain three times a day. Favorable action is the releasing of some of the rigidity, thus making it easier for patients to talk, eat and move about and carry on their ordinary activities. The drug should be brought to a point where the maximum effect is established and then an attempt made to maintain the patient at this level. As the disease is progressive, one cannot expect to maintain a high level continuously, and increasing the dosage of scopolamine in order to do this usually leads to toxic symptoms from the drug itself. Much relief, however, can be expected in most instances by careful use of these drugs; but constant supervision is necessary in order to get the maximum effect without untoward symptoms.

PROTEIN INTAKE IN ECLAMPSIA

To the Editor:—I have seen little if anything on the newer advances in the treatment of eclamptic patients. Is it considered good treatment as yet to give a high protein diet when patients are excreting large quantities of albumin in the urine, as is true in nephrotic stages of nephritis? If not, why not? Best, in his new book, suggests that this is true but fails to come out flatfootedly in favor of it. Eyebrows have been raised when I have resorted to this practice, but patients seem to do well and I should like to know whether I'm with the "accepted" or on "outcast."

Walter R. Miller, M.D., San Pedro, Calif.

ANSWER.—Contrary to old beliefs, proteins given to women who have toxemia of pregnancy not only do no harm but actually are beneficial. On the other hand, the administration of large amounts of sodium in the form of table salt, sodium bicarbonate or "patent medicines" rich in alkaline salts may bring about severe symptoms of toxemia of pregnancy. M. B. Strauss (*Am. J. Obst. & Gynec.* **38**:199 [Aug.] 1939) gave sodium to 10 women with low plasma proteins and produced significant gains in weight, obvious edema, hypertension, increasing albuminuria and in 3 instances such preeclamptic symptoms as headache, visual disturbances, vertigo and epigastric pain. When the retained water could be eliminated, all these manifestations subsided. Since hypoproteinemia is one of the more important factors which permit the development of water retention, adequate antepartum care must include attention to the prevention of this condition. Although disturbances of absorption, assimilation, manufacture and urinary loss of protein may be involved, it appears that the chief cause of hypoproteinemia in pregnancy lies in inadequate dietary intake of protein of good biologic values, especially in view of the increased demands for protein for the developing fetus and also for the maternal organism. It is therefore of the greatest importance that the diet in pregnancy contain more, not less, protein than an adequate diet for nonpregnant subjects. Hypoproteinemia results in water retention. Two Gm. of protein per kilogram should be administered, if necessary, to combat loss of protein through excretion. Treatment of true eclampsia is similar to that of nephrosis. The protein should be relatively free of sodium ion. It is likewise important that the pregnant woman avoid an excessive intake of sodium salts under any conditions, and, if she has low plasma proteins, sodium restriction must be used. Anemia, which is conducive to water retention, is to be avoided by proper prophylactic measures. It is certainly safe for women with toxemias of pregnancy to take 60 Gm. of protein daily and in addition 30 Gm. of fat and 400 Gm. of carbohydrate.

ALLERGIC CONJUNCTIVITIS

To the Editor:—A widow aged 58 has as her chief complaint periodic severe conjunctivitis. The attacks occur at intervals of from two weeks to two or three months, never starting in the same eye but invariably affecting both eyes before the attack is over. The swelling and redness of the conjunctiva are preceded by severe "pulling" back of the eyeballs and soreness of the whole head during the height of the eye inflammation or conjunctivitis. The mucosa of her nose will assume a fiery red appearance with occasional slight bleeding. Her external ear will look as in erysipelas, swollen and bluish red and sore to touch. This redness will extend to the eardrum around the external auditory canal. At the height of the conjunctivitis the nose culture yields Staphylococcus albus, and a small pimple on the ear during one of these attacks contained Staphylococcus albus. She has no rise in temperature. Her blood cell count is not changed during these attacks and her physical condition is normal. The blood pressure is 140 systolic and 80 diastolic. The urine is negative to albumin and sugar. The specific gravity varies but little. She is high strung and worries about herself and eyes a great deal, but this does not prevent her from doing housework in various places nearly all the time. Since her eyes started to bother her she has had a complete hysterectomy and a perineal repair and has had various intramuscular and intravenous treatments of endocrine substances, vitamin combinations of various kinds and staphylococcus vaccine and foreign protein. Salicopyridine and sulfathiazole have been used and also sulfanilamide. Her condition is just as bad now as it was three years ago. Are there any suggestions or is there any authority that I can consult that will be of help? When she has the conjunctivitis in the right eye it will be the right ear that will be inflamed, and when the conjunctivitis is in the left eye it will be the left ear that will be inflamed; if both eyes are inflamed both ears will be inflamed.

D. C. Y. Moore, M.D., Manchester, Conn.

ANSWER.—The history and observations in this case sound like those of a typical case of nasal and conjunctival allergy. A scraping and smear of the conjunctiva and nasal mucosa should reveal a large number of eosinophils.

The intradermal testing for the causative agent may reveal little, as cutaneous tests seem to be of little value in allergic conditions of the eye. A careful history of exposure to irritative agents may locate the cause. Particular attention should be paid to contacts, probably inhalants in the place she worked the day before or on the day when the attack occurred. Cases in which powdered soap caused such trouble have been noted, and, of course, animal fur is a common cause. If contact sensitivity is not found, a careful search for food allergy should be instituted. Such foods as pork and shellfish, eggs or fowl are among the common causes of conjunctival allergy.

SULFANILAMIDE FOR PERITONITIS AND AFTER APPENDECTOMY

To the Editor:—I should like information regarding the use of sulfanilamide deposited at the area of the appendical stump after an appendectomy. There has been a difference of opinion locally among surgeons as to its value. One of the criticisms offered is that the sulfanilamide is altered during the process of autoclaving for sterilization and that the new chemical resulting has not the desired effect. Is there any report on the use of sulfanilamide deposited at the area of the appendical stump in cases of ruptured appendixes with peritonitis or of acute suppurative appendicitis without rupture? If some surgeons have used the drug in this manner, what has been their method of sterilizing it and what has been the average amount of the drug placed in the peritoneal cavity? With the use of sulfanilamide in cases of peritonitis has drainage been used, and if so what type of a drain, or has complete closure without drainage been used?

Barney Liba, M.D., Vineland, N. J.

ANSWER.—The sterilization of sulfanilamide powder is not a difficult procedure. Key and Burford (*South. M. J.* **33**:449 [May] 1940) state that they have autoclaved sulfanilamide powder in a bottle that was not tightly sealed. One can also sterilize sulfanilamide by heating the powder at 140 to 145 F. for a period of two hours. If the temperature is kept constant throughout the period of sterilization, no chemical change will occur in the sulfanilamide. Ravdin and his associates (*Ann. Surg.* **111**:53 [Jan.] 1940) have reported on the oral use of sulfanilamide in the prophylaxis and treatment of peritonitis associated with appendicitis. Recently one of these observers has stated that sulfanilamide crystals have been introduced with satisfactory results directly into the peritoneal cavity in cases of peritonitis. The question of drainage or closure in peritonitis due to acute suppurative appendicitis is still an open one. Ravdin and his associates stated "When widespread peritonitis was present and the local exudate extensive, the appendical site was usually drained with iodoform packing covered with a sheet of rubber dam, the lateral colic gutter with a cigaret and the pelvis with a soft rubber tube or a cigaret and a tube. In such cases the wound was closed loosely." In pneumococcic, gonococcic and beta hemolytic streptococcus peritonitis it is a good plan to close the abdomen completely and not to attempt drainage if the best results from the use of sulfanilamide or its derivatives are to be obtained.

CHRONIC SUPPURATION OF NECK AFTER TONSILLECTOMY

To the Editor:—Three months ago I removed the tonsils of a man under local anesthesia. The operation was performed in the usual manner with procaine and epinephrine tablets. About ten days later he noticed that he could not open his mouth as wide as usual, which condition was followed by a progressive swelling in the area of the angle of the mandible. This became worse and fever developed. Four weeks after the operation he was hospitalized and a large amount of foul smelling pus was evacuated from what I decided was the pharyngomaxillary fossa. Penrose drains were put in and left for several days. Since then small pus pockets have formed in the region in front of the sternocleidomastoid muscle and above the hyoid bone requiring frequent drainage. When drainage ceases, the site of the original swelling becomes inflamed and swollen, again producing a fever. He has been able to work as long as the drainage is not interrupted. We have used roentgen therapy, sulfanilamide internally and the powder in the sinus tracts, and sulfathiazole in proper dosage without any permanent relief. Several specialists have seen him but they have not been able to suggest anything more than was being done. We have not identified the causative organism nor have we tried an autogenous vaccine. Would you suggest a method of treatment that might relieve this condition?

M.D., Indiana.

ANSWER.—The condition of the patient's general health should be thoroughly investigated, with particular emphasis on tuberculosis. Any deficiency that may be detected during the study should be corrected. Local measures of irrigating the fistulous tracts with mercury bichloride 1:8,000 or hexylresorcinol full strength may be tried, if they have not already been used.

Repeated bacteriologic studies should reveal the causative organism or the predominating ones; an autogenous vaccine may be used.

Infra-red irradiation to the fistulous tracts or the application of ultraviolet rays, either air cooled or water cooled, are sometimes helpful.

Failure to attain any degree of success by conservative means would necessitate, after due deliberation, recourse to surgical measures.

A regular dissection of the neck with the view to dissecting out the fistulous tracts, as well as the exposure of the lymph nodes underneath the sternomastoid muscle, the pharyngomaxillary fossa and such other processes and also of the deep cervical fascia where connective tissue is abundant and where blood vessels, lymph vessels and nerves travel through might reveal the locus or loci of the persistent suppuration.

The danger of thrombosis of the internal jugular vein is probably remote now, because sufficient time has elapsed for the development of defensive mechanisms.

DEMENTIA PARALYTICA

To the Editor:—A white woman, married, aged 36, has a diagnosis of central nervous system syphilis with dementia paralytica. The blood Wassermann reaction is 4 plus and spinal fluid examination was as follows in March 1938: Wassermann 4 plus, colloidal gold 5555543210, cells 97 per cubic millimeter. She was given therapeutic malaria in March 1938 and during a period of two weeks had nine chills, with a spontaneous remission after the ninth. Subsequently she was given twenty-one intravenous injections of aldersone (a pentavalent arsenical, sodium methylene-sulfoaminohydroxy-phenyl arsenate). After the twenty-first treatment she had what appeared to be an arsenical reaction. The arsenical was stopped and courses of bismuth salicylate were alternated with mercuric succinamide as follows: aldersone twenty-one injections (0.25 Gm., 0.5 Gm. and the remaining 1 Gm. each); bismuth salicylate thirty-six intramuscular injections of 2 grains (0.13 Gm.) each; mercuric succinamide twenty-three injections of ½ grain (0.01 Gm.) each. The last injection of bismuth was given on July 15, 1940. At the present time both blood and spinal fluid Wassermann reactions are 4 plus. There has been good symptomatic improvement. Please criticize and suggest plan of future care.

M.D., Minnesota.

ANSWER.—There is nothing to criticize in the program thus far. The full effect of the fever therapy has not as yet been reached, as the majority of the patients manifest the maximum benefit approximately three years after the fever course has been completed. Symptomatic improvement usually precedes by a year or more the serologic reversals. The best results in dementia paralytica have been seen in patients who were given tryparsamide and bismuth compounds after the fever course, and, although the patient in question displayed an arsenical reaction, it would seem advisable to try her now on tryparsamide and bismuth compounds. Before this treatment is started the patient's eyegrounds should be checked and if abnormalities of syphilitic origin are found the tryparsamide should not be given. Also in view of the demonstrated sensitivity to arsenic the doses of tryparsamide should be small, starting with 0.5 Gm. and increasing the dose slowly, stopping on the slightest sign of cutaneous reaction. It is not uncommon for patients to tolerate tryparsamide satisfactorily, although they showed evidence of intolerance to an arsphenamine. If the tryparsamide is tolerated the patient may be given ten injections of tryparsamide and a bismuth compound to a course, with a two month rest between courses for a total of at least seventy-five injections of each drug.

TETANUS FROM MIDDLE EAR INFECTION

To the Editor:—A patient recovered from severe tetanus six months ago. Enormous doses of specific antitoxin were used. The organism was recovered from a chronic middle ear discharge. A modified radical mastoidectomy was performed but the ossicles and tympanum could not be removed. The ear discharge continues but the organism can no longer be recovered. The question of further management of this case arises. Do you think that further operative therapy directed toward complete eradication, if possible, of the focus is indicated? If the organisms are present in the depths of the middle ear or its neighboring bone, do you think that the patient possesses enough passive or active immunity to protect him against another attack of tetanus? Do you think that a course of tetanus toxoid with repeated injections at yearly intervals is indicated?

M.D., New York.

Answer.—If the patient is symptom free and in good physical condition it would be inadvisable to operate because tetanus might be stirred up again by the surgical trauma induced, in the endeavor to eradicate the focus completely.

It is difficult to evaluate with precision just how much immunity, active or passive or both, the patient now possesses, but that he has immunity is proved by the fact that he has recovered.

Whether he has a sufficient reserve of immunity to protect him against another attack is questionable.

A course of tetanus toxoid with repeated injections at yearly intervals should be undertaken, however, in order to heighten immunologic powers. At the same time gentle conservative treatment to the involved ear may be carried out at regular intervals, using wicks of cotton soaked with peroxide, then dried and replaced with cotton twists soaked in 50 to 70 per cent alcohol. Baking before an infra-red lamp for twenty minutes may be carried out with the cotton-alcohol ear pack.

A conservative policy may be followed unless indications arise that might demand radical measures.

BAD FEEDING HABIT IN NINE MONTHS OLD BABY

To the Editor:—A boy aged 9 months seems to have a bad tendency to drink his milk at night on the average of four bottles, using Baker's modified milk feeding. During the day he has his fruit, vegetables, egg, cod liver oil and vitamins but seems to have the profoundly embarrassing habit of wanting to drink milk during the night at intervals of one to two hours. I have used sedatives at bedtime, later repeated, and have tried to overfeed him before bedtime but unwisely have failed to correct his night bottle milk drinking. Could you suggest anything—any trick of the trade other than permitting him to cry half the night to learn that he is not supposed to do his "drinking" at night? Incidentally, pediatricians have advised me that as long as the boy is in excellent health, feed him. It is hard on his parents, however.

M.D., Pennsylvania.

Answer.—Drinking milk at night by a healthy infant 9 months old is nothing more or less than a bad habit established by not eliminating the 2 a. m. feeding by 6 weeks of age and the 10 p. m. feeding by 6 months of age. It differs in no way from the adult who must raid the ice box before bedtime. There is only one treatment and that is to stop any feeding or drinking between 6 p. m. and 7 a. m. Naturally the infant will put up a fight to continue a pleasurable habit, as apparently thus far he has been victorious. However, each successive night he will cry less and less, until finally he will learn that it is better to sleep at night. It is justifiable to use a sedative (the proper dose of one of the barbiturates) for a week or two to diminish his resistance to the breaking of the habit; also to enable the attendant or parents to obtain more sleep. The sedative can be gradually decreased as the infant rests more comfortably. The longer the inevitable is postponed, the more difficult will it be to break this habit.

TRANSPOSITION OF CORD IN FRONT OF FASCIA IN HERNIA OPERATION

To the Editor:—What are the contraindications, if any, during a hernia operation to the transposition of the cord in front of the fascia, leaving it free behind the subcuticular fat? Is there any objection to this procedure, and has it been used in any type of operation? If so, may I have the name of the operation?

M.D., Massachusetts.

Answer.—There are no contraindications to transposition of the cord in front of the fascia during the hernia operation. The procedure is described by Seward Erdman (in Christopher, Frederick.: Textbook of Surgery, ed. 2, Philadelphia, W. B. Saunders Company, 1939, p. 1309):

"Extra-aponeurotic transplantation was first practiced by Halsted and later modified by Andrews, Woolsey, Stetten, Downes and Erdman. It is indicated in direct hernia and in old large obliques, also in most recurrent hernias. This operation makes use of a strong fascia to fascia overlap of the aponeurotic flaps to fortify Hesselbach's triangle and its weak inner angle. In direct hernia the sac bulges through the posterior wall of the structures of the cord. After the cremaster is split the transversalis fascia must be opened to expose the sac. After excision of the sac the hernioplasty proceeds (*a*) with separate suture of the transversalis fascia, (*b*) suture of the conjoined muscle to Poupart's ligament and, (*c*) with the cord still elevated, the upper or mesial leaf of aponeurosis is sutured to Poupart's ligament and the lower leaf is overlapped upward and sutured to the surface of the upper leaf. Sometimes it is best to excise the cremaster from the canal. The cord then emerges through the aponeurosis opposite the internal ring and runs down toward the scrotum subcutaneously."

SPINAL ANESTHESIA FOR OBSTETRICS

To the Editor:—What is the present position of spinal anesthesia in obstetric practice? Should one introduce it in a forty bed hospital in a community of six thousand people?

O. O. Lyons, M.D., Powell River, B. C., Canada.

Answer.—Spinal anesthesia is in use in but few clinics in this country. The method carries greater danger for the obstetric patient than for the nonpregnant woman. It arrests the progress of labor and increases the incidence of obstetric complications. The only indication for its use would be a person for whom inhalation anesthesia was contraindicated, although local infiltration and nerve block are equally effective and less hazardous to the mother. It would be distinctly unwise to introduce spinal anesthesia in an obstetric service of a small hospital.

HEREDITY IN LEUKEMIA

To the Editor:—A woman aged 30 requested me to obtain information on heredity of leukemia. She had a child who at the age of 3 died of myelogenous leukemia. She would like to have another child but is in mortal fear that this tragedy may recur.

Herman F. Senft, M.D., Lakewood, N. J.

Answer.—There is little basis for the mother's fear of a recurrence of leukemia in her next child. Up to 1933 there were only eleven authentic reports of leukemia occurring in members of the same family. The majority of these cases were of the lymphatic type (Petri, S.: *Acta path. et microbiol. Scandinav.* **10**:330, 1933). The chances of such an occurrence in this family are therefore slight.

There is no conclusive evidence of an hereditary basis for leukemia in man. In mice, however, several investigators (Slye, Macdowel, Richter) have shown that leukemia, particularly lymphatic, like a neoplasm, is subject to genetic control, governed by mendelian laws. This subject is fully discussed by Slye (*Am. J. Cancer* **15**:1361 [July] 1931) and by Richter in Downey's Handbook of Hematology (New York, Paul B. Hoeber, Inc., 1938, vol. 4, p. 2998).

WIRES AND PINS FOR FRACTURES

To the Editor:—Will you kindly publish a statement regarding the sites for the placement of Kirschner wires and Steinman pins in both the upper and lower extremities?

Edwin B. Bailey, M.D., Linton, Ind.

Answer.—Transfixing Kirschner wires and Steinman pins through bones can be used at any site to maintain traction or fixation by incorporating them in plaster of paris casts. Böhler's book "Treatment of Fractures" gives a good description of the way in which these pins should be used. Dr. H. Winnett Orr's articles on the treatment of compound fractures are available in the current literature, and he describes the use of pins.

If traction is to be used, generally speaking the pins and wires are better placed through the expanded end of the bone in which the traction is to be used; for example, the lower end of the femur for fractures of the femur and the lower end of the tibia for fractures of the tibia.

PHENOL FOR BURNS

To the Editor:—I remember hearing, years ago, of the treatment of first and second degree burns with phenol (carbolic acid). The idea was that phenol coming in contact with the raw surfaces would form an albuminate of phenol, which is an impermeable membrane. It is also analgesic and antiseptic and closes the lymphatics, thus preventing absorption. I am anxious to know if any research has been done along these lines and how much surface could be painted without causing phenol poisoning.

Joseph L. DeCourcy, M.D., Cincinnati.

Answer.—While the single application of phenol has been recommended for first and second degree burns, all authorities condemn its use. The antiseptic and analgesic properties of this drug are more than outweighed by the fact that it acts as a protoplasmic poison. The dangers of irritation of the wound and phenol poisoning are definite contraindications to its use.